University of Alberta

Coping With the Abortion Experience:
Restoring Wholeness—Tending the Garden

by

Jadwiga Maria Straszynska, R.N. ©

A thesis
submitted to the Faculty of Graduate Studies and Research in partial
fulfillment of the requirements for the degree of Master of Nursing

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled **Coping With the Abortion Experience: Restoring Wholeness—Tending the Garden** submitted by Jadwiga Maria Straszynska in partial fulfillment of the requirements for the degree of Master of Nursing.

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To women who, in the face of social prejudice, have made courageous choices, acted upon them, and taken full responsibility for their actions.

To people who, in various ways, are committed to the well-being of women by providing care or advocating for change.

Abstract

The grounded theory method was employed to generate a substantive theory of the coping process with the abortion experience. The core process of restoring wholeness, which included three stages—(a) surviving the struggle, (b) beginning the process of healing, and (c) becoming whole—was identified. To represent this process, the metaphor of "Tending the Garden" was used as a central image. This metaphor is emblematic of the effort of bringing closure to the abortion experience, which resulted in personal growth as demonstrated by each participant. Data were collected from 13 unstructured individual interviews with 12 women and one focus group consisting of three women. All respondents were between 23 and 67 years of age and had had abortions between the ages of 18 and 32.

Coping with the abortion experience was demanding and complex. Confronting the decision to abort, which initiated the coping process with such an experience, constituted the most difficult challenge. Despite the reasonableness of the decision, the struggle with unattainable social ideals continued until the moment preceding the abortion. For the majority of the participants, the period following their abortions brought a sense of relief. However, this sense of relief also brought other challenges. Abortion was associated with loss. Healing which involved the expression of grief emerged as a cyclical process. The conclusions from this research study will help nurses create an environment conductive to healing and personal growth for women coping with the abortion experience.

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CHAPTER 1

INTRODUCTION

Statement of the Problem

As sexual human beings, the majority of women, especially during their childbearing years, are engaged in intimate relationships with men. For approximately 35 years a woman has the capacity to bear children. During this period of time a number of women face unexpected pregnancy, single parenthood, and abortion. It is estimated that 70,463 therapeutic abortions were performed in Canada in 1991, including 6,335 in Alberta. These numbers translate to rates of 10.9 per 1,000 Canadian women aged 15-44 and 10.2 per 1,000 in Alberta, respectively (Wadhera, 1991). It is also predicted that more than 30% of all Canadian women will have at least one abortion during their childbearing years (Millar, Wadhera, & Henshaw, 1997). These statistics support the contention that abortion is a significant health issue denoting concerns for both women who directly experience it and nurses who deliver abortion care. Despite this fact, little research has been undertaken exploring experiential knowledge about coping with the abortion experience which would thereby help nurses provide women with adequate care.

Although it has been performed since ancient times, abortion is rarely recognized as a component of overall wellness. Instead, in discussions that are highly charged with emotion, abortion is viewed as violence against the unborn, whereas by contrast women's well-being is generally ignored. Conflicts of competing moral values regarding fundamental rights to life, privacy, and control over one's body have polarized the modern debate concerning the issue of abortion. In particular, the moral standing of the fetus arises as one of the most challenging questions that provoke this controversy surrounding abortion. The potency of controversial language and the moral opposition against abortion stifle the voices of women who possess experiential knowledge, and thus deeper insights into the psychological aspects of this issue. Without exploration of women's psychological perspective, health professionals might not adequately understand how abortion affects women's lives (Petchesky, 1990; Sherwin, 1995), and how women cope with such experiences.

Although abortion has recently emerged as a significant health issue that integrates somatic, emotional, and social aspects of women's well-being (Marck, 1994; Stotland, 1991), lack of insight into women's personal knowledge might affect nursing practice, education, and future research. Usually, health professionals view abortion as a medical procedure (Sherwin, 1995); this perspective pervades the research literature. Consequently, medical and nursing literature, including textbooks, lack sufficient knowledge about the health needs of the women going through the abortion experience. The literature, therefore, has not offered any substantial health-promoting guidelines for nurses providing care to women who have had abortions. Without adequate knowledge and understanding of women's coping patterns, health professionals, including nurses, cannot provide women who are contemplating, or who have already had, abortions with appropriate care.

Historically, abortion has been perceived as a moral deviation by some sectors of society (Lunneborg, 1992; Sherwin, 1995). However, women who have personally experienced it might view abortion as an important aspect of their health. Nevertheless, the health of women having an abortion has been jeopardized by verbal abuse and physical violence directed towards both the women and the practitioners providing the service (Brink, 1995; Sherwin, 1995). Also, some practitioners who lack understanding of the subjective experience of having an abortion treat their clients with resentment and hostility (Marck, 1991, 1994; Sherwin, 1995). Prevailing antagonistic attitudes and mistreatment might negatively influence women's perceptions of their abortion experience and, consequently, their coping mechanisms.

Although a number of researchers have investigated certain aspects of coping, the researcher has found no research that addressed this issue directly from the women's perspective. For example, Major, Mueller, and Hildebrandt (1985) studied casual attributions, expectations of coping, and the ability to find meaning in the abortion experience. By using questionnaires, these researchers collected data from 247 women 30 minutes after the abortion and then three weeks later. Responses elicited by those methods, however, might not capture the full range of possible behavioral manifestations of coping. According to Morse and Field (1995), quantitative methods have limited access to women's contextual knowledge, and therefore cannot adequately reflect the etiology of the underlying psychological coping processes. Furthermore, despite the possibility of the long-term implications of abortion, most research has failed to identify coping mechanisms with such experiences (Butler, 1996).

Research that investigates the process of coping with the experience of abortion is of paramount importance for several reasons. First, it will illuminate the coping process in the context of women's experiences rather than through personality traits, thereby increasing the existing body of knowledge. Second, it will help women make wiser and more educated choices relating to the control of their fertility. Third, it might help women better understand experiences associated with their abortions, thus better enabling them to cope with such experiences. Fourth, it will encourage health professionals to examine their values and beliefs concerning abortion, better enabling them to develop sensitivity to the values and beliefs of others. Fifth, this research will provide health professionals with a broadened understanding of the issue of abortion, better enabling them to make enlightened choices about whether to provide abortion care. Finally, findings from this research will equip health professionals with sound knowledge to provide quality care to their clients and to promote the reproductive aspect of their health. In addition, this research might render a conceptual framework for further research in this field.

Purpose of the Study

The purpose of this study was to generate a theory which would help explain the social psychological processes used by women to achieve closure of the abortion experience.

Research Questions

The key question that guided this research study was, "What is involved in the process of coping with the abortion experience?" Secondary questions helped organize a detailed study of this coping process:

1. How do women go through their experiences of having abortions?
2. How do women feel about their abortions?
3. What do women learn from their abortions?

4. What was the most difficult aspect of the abortion experience? How do women come to terms with it?
5. What would women do differently to make the abortion experience easier on themselves?
6. What would participants share with pregnant women considering an abortion?
7. How can health professionals who deliver abortion care help women better cope with their experiences?

Significance of the Study

Because abortion is considered a frequent surgical procedure (Gottlieb, 1995; Lethbridge, 1995), nurses working in all areas of practice will encounter women who have had abortions and might need assistance in achieving closure from the experience. Abortion, a significant health concern, is also related to other health issues such as sexuality, family planning, and fertility. Nurses typically provide abortion care to women within the setting of an abortion clinic. However, nurses working in other settings are in a unique position to help women address various health issues surrounding their abortion experience.

The crucial ingredients of caring for women having abortions include understanding, sensitivity, and openness to both their experiences and their self-knowledge (Marck, 1994). To develop caring attitudes toward women undergoing abortion, nurses must possess a sound knowledge base and in-depth understanding about how abortion might be experienced (Kesselman, 1990; Lethbridge, 1995; Sherwin, 1995). By delivering appropriate and effective care, nurses will enhance women's ability to cope successfully with their abortion experience. The findings of this study will contribute to nursing knowledge by generating a theory from the women's perspective. This beginning theory will help to explain the process of coping with the abortion experience, thereby offering nurses deeper insight into the nature of this phenomenon. This theory could serve as a guide during the assessment, planning, and implementation of nursing care to meet the needs of women either contemplating, undergoing, or already having had abortions.

CHAPTER 2

REVIEW OF THE LITERATURE

The research literature was reviewed to obtain a general picture of work that had already been done in the field. Such a review was helpful to establish a rationale for this study. In this search, the researcher identified several themes concerning abortion. These themes will be discussed under the following subheadings: (a) abortion: informed option, (b) decision: an unfolding process, (c) the psychological effects of abortion, and (d) manifestations of coping: conceptual lens.

Abortion: Informed Option

Those segments of the society who oppose abortion (MacKinnon, 1994; Petchesky, 1990; Shepler, 1991) and those professionals who lack insight into women's subjective experience (Marck, 1994) have offensively portrayed women as irresponsible, selfish, and frivolous in making abortion decisions. However, significant evidence supports the claim that women often do make responsible decisions about having abortions (Gates, 1990; MacKinnon, 1994; Petchesky, 1990; Robson, 1985; Shepler, 1991; Sherwin, 1995). For instance, a woman who was violently or coercively forced to have sex and became pregnant might not wish to carry the pregnancy to term (Petchesky, 1990; Shepler, 1991). Women might become unintentionally pregnant by men who are unwilling to practice safe sex or through ineffective contraceptives (MacKinnon, 1994; Shepler, 1991). Some women cannot use contraceptives for medical reasons (Robson, 1985). Many women might not wish to conceive due to economic insecurity, lack of adequate financial resources, or not being prepared to assume the responsibility for caring for children. Women with limited financial resources might perceive themselves as being unable to cope with the subsequent emotional stress associated with this situation (MacKinnon, 1994; Petchesky, 1990; Robson, 1985; Rosenfield, 1994; Sherwin, 1995). In addition, women who are committed to achieving personal goals might not be ready to become mothers (Robson, 1985; Sherwin, 1995).

An unwanted pregnancy can pose a risk to a woman's well-being. It also might result in decreased quality of life for the child born from this pregnancy. Some women do not want a new child to live in poverty or in an unstable dyadic relationship (MacKinnon, 1994; Robson, 1985), or to have a life that would be helpless and futile due to mental retardation and/or severe physical deformity (Gates, 1990; Gay, 1994).

In such circumstances women choose abortion to conclude an unexpected pregnancy because of concerns for themselves and for newborn children (Gates, 1990; Petchesky, 1990; Robson, 1985). Abortion, in combination with contraceptives, gives women voice and choice in handling their reproductive situations. Choices regarding reproduction allow women to maintain or achieve optimal health, enjoyable personal lives, and desired social positions (Gay, 1994; Petchesky, 1990; Robson, 1985; Shepler, 1991; Stotland, 1991; Timpson, 1996).

Decision: An Unfolding Process

Using a phenomenological approach, Robson (1985) brought to light the complexity of the intensely stressful decision-making process involved in abortions. The findings of her study reveal that the decision to abort is an unfolding process which includes the following four stages: (a) acknowledgment of pregnancy, (b) formulation of alternative outcomes, (c) consideration of the relative merits of the available options, and (d) commitment to the chosen outcome.

In the first stage women used denial to avoid the reality of pregnancy and of having to make a difficult decision. Before confirmation of the pregnancy, each woman, anticipating her upcoming menstrual cycle, had desperately hoped that the delay in her menses was due to reasons other than pregnancy. Upon acknowledgment of pregnancy, women experienced shock and dismay.

During the second stage women investigated the options that were open to them. In Robson's (1985) study, only two options were considered: abortion or motherhood. All women felt that they would have developed a strong attachment to newborn babies and therefore could not separate themselves from them. For that reason they did not consider adoption as a viable option.

In stage three each woman examined and evaluated the different issues that comprised her personal and complex situation. Each independently followed a pattern that was composed of three major themes: personal issues of autonomy and self-determination, issues of moral life, and social consideration of normative expectations and support systems.

During stage four, each woman made a commitment that reflected her decision and assumed full responsibility for her chosen alternative. However, some women continued to feel ambivalent about the final decision (Robson, 1985), which included the psychological pain of accepting or rejecting motherhood (Marck, 1991). Overall, a woman makes her decisions about abortion within a complex social context.

The Psychological Effects of Abortion

A vast body of scientific knowledge on abortion has been predominantly generated by quantitative-descriptive rather than theory-generating research. (Adler et al., 1990, 1992; Armsworth, 1991). By far, the majority of the research literature focused on the impact of abortion on women's mental health either from the clinical or the Freudian psychoanalytic perspective directed at psychopathology (Adler et al., 1990; 1992; Armsworth, 1991). However, most researchers agreed that women who have had abortions might experience a variety of emotions, both positive and negative. The results of a review of the research literature on abortion conclude that abortion poses no psychological hazard for women. This review confirmed the notion that infrequent negative psychological responses are likely to occur shortly after abortion, and the greatest distress might occur before the abortion (Adler et al., 1990; 1992, Armsworth, 1991; Doane & Quigley, 1981; Koop, 1989; Lunneborg, 1992; Rosenfeld, 1992).

Furthermore, adverse psychological reactions to abortion that occur sporadically are usually related to symptoms that women experienced before the abortion. By contrast, women displayed more negative psychological responses when abortions were denied (Dagg, 1991). Although severe negative psychological responses to abortion are rare, these can be dramatic. For example, Kopferschmitt, Thomann, Mack, & Mantz (1989) conducted a study with 22 French women and pointed out that abortion could precipitate suicidal tendencies in some women. Earlier, Susan Stanford (1986) in her evocative story revealed her dramatic post-abortion experience which led to depression and an attempted suicide, although there is little evidence supporting claims that most women having abortions experience severe post-traumatic stress (Doane & Quigley, 1981).

Some negative emotional reactions following abortion might be socially and internally based. In response to the social stigma and norm violation associated with an abortion, women might experience shame, guilt, fear of discovery, and disapproval. A broad range of negative emotions from regret to hostility might arise from women's personal understanding of pregnancy and its termination (Adler et al., 1990; 1992; Castle, Harvey, Beckman, Coeytaux, & Garrity, 1995; Lapple, 1994; Lunneborg, 1992; Major et al., 1985; Stewart & Stotland, 1993; Stotland, 1991).

Several researchers investigated personality traits and self-concepts of women seeking first or repeated abortions. They concluded that there is no relationship between personality traits and the number of abortions (Polk-Walker, 1993; Russo & Zierk, 1992; Thompson & Robinson, 1986).

Using an empirical study method, Polk-Walker (1993) examined differences in psychological distress among 150 women who had abortions under local and general anesthesia. Her findings show that women having an abortion under general anesthesia experienced more psychological distress than those having abortion under local anesthesia. According to Polk-Walker, some women who had an abortion under general anesthesia exhibited depression, hostility, and psychosis. Furthermore, those women were likely to deny both having an abortion and responsibility for the abortion. Consequently, their choice of general anesthesia might reinforce their denial system and distance them from the experience of abortion. In turn, such distancing might interfere with women's ability to integrate the abortion decision and its consequences into their concepts of themselves.

Armsworth (1991) pointed out that women who used denial were more depressed following abortion than were those who were able to talk about their experiences and discuss prevention of future pregnancies. An alternative view suggested by other authors is that women do not deny abortion as the outcome of personal choice, but rather as a deviant act. Denial of deviation rather than denial of abortion suggests an explanation for why some women reveal a decrease in post-abortion distress (Armsworth, 1991; Turell, Armsworth, & Gaa, 1990).

A collection of studies on women's health reported the positive aspects of abortion. The tenor of this research literature is that happiness and relief are predominant feelings that women experience immediately after an abortion (Adler et al., 1992; Lazarus, 1985; Rosenfeld, 1992). Moreover, a sense of control over one's life that improves self-image and enhances self-esteem is often portrayed as the outcome of abortion (Adler et al., 1990; Lunneborg, 1992; Stotland, 1991). However, at times the experience of abortion might be painful for some women (Stanford, 1986).

Several studies have suggested a significant link between different psychological responses to abortion and factors that might influence them. These factors include the decision-making process, perceived social support, and self-efficacy expectations (Major et al., 1984; Robson, 1985). Women who are adequately supported during the decision-making process, are satisfied with their subsequent choices, have high coping expectations, and terminate first-trimester cope better (Adler et al., 1990, 1992; Armsworth, 1991; Butler, 1996; Castle et al., 1995; Dagg, 1991; Lemkau, 1988; Lunneborg, 1992; Major et al., 1985; Robson, 1985; Stewart & Stotland, 1993; Stotland, 1991). The other forces that might have a strong impact on shaping women's experiences include professionals' attitudes, women's previous experiences with health care providers, abortion procedures (Marck, 1991), and events subsequent to the abortion (Adler et al., 1990, 1992).

Manifestations of Coping: Conceptual Lens

Posvac and Miller (1990) conducted a quantitative review of 24 empirical studies on the psychological impact of abortion. They identified five processes that might explain psychological responses as manifestations of coping with the abortion experience. Those processes are (a) relief hypothesis, (b) dissonance hypothesis, (c) dissimulation hypothesis, (d) guilt, and (e) bonding hypothesis.

The first hypothesis is based on the assumption that women with unexpected pregnancies experience intense stress and anxiety until these pregnancies are ended. Correspondingly, those women experienced marked relief and a normal adjustment after an abortion was obtained. According to the dissonance hypothesis, a woman experiencing "pressing" thoughts decides to eliminate pregnancy in spite of her moral reservation about having an abortion. Subsequently, this experience of dissonance leads the woman to change her attitude towards abortion to fit her behavior (Burnell & Norfleet, 1987; Posvac

& Miller, 1990). According to the dissimulation hypothesis, a woman might deliberately act as though she will be psychologically harmed by the pregnancy until an abortion is contemplated. After having had the abortion, the woman has no further need to look distressed; therefore she presents herself as healthy and well-adjusted.

Posvac and Miller (1990) have supported the notion that guilt and shame associated with having an abortion can be inflicted on women by those individuals who demonstrate strong moral opposition to abortion. Following similar lines of reasoning, other investigators (Gottlieb, 1995; Marck, 1991; 1994; Robson, 1985; Turell et al., 1990) contended that women's emotional reactions to abortions are influenced by societal attitudes about abortions and the cultural climate in which abortions occur. According to the bonding hypothesis, women already grieve losses before approaching an abortion. The experience of anticipatory grief might have a positive post-abortion effect, thereby enhancing the resolution of the abortion (Peppers, 1987-88; Posvac & Miller, 1990).

Summary

The research literature has emphasized that women who have had abortions might exhibit a mixture of positive and negative emotional responses. Such responses, however, have never been systematically investigated from the emic perspective. Despite the bulk of the literature pertaining to women's psychological responses, the long-term ramifications of abortion have not yet been adequately addressed. Regardless of whether those responses are positive or negative, they might reflect on the entire course of experiencing and resolving unexpected pregnancies (Adler et al., 1990; 1992; Armsworth, 1991; Lunneborg, 1992; Stotland, 1991). Correspondingly, Posvac and Miller (1990) have suggested that the resolution of abortion might involve complex sociopsychological processes.

Nevertheless, throughout the review of the literature the researcher found no studies that comprehensively focused on the process of coping with the experiences associated with abortion. Consequently, coping mechanisms that women employ to bring closure of their abortion experience remain largely undiscovered or unexplained. Thus, additional research that investigates the process that women pass through as they attempt to achieve closure of such experience is important. The findings of this study will contribute to an increased understanding of the process of coping with the abortion experience, thereby expanding nursing knowledge, which will result in better care for women.

CHAPTER 3

METHODOLOGY

The purpose of this study was to generate a theory that would explain the process of coping with the abortion experience. In this study the researcher defined *coping* as the ability to adapt to change, to withstand destructive social forces, and to transform painful experiences into health-promoting events. When conducting a scientific investigation, researchers must choose a method that can appropriately address the research question, the purpose of the research study, and the nature of the phenomenon under study (Morse & Field, 1995). In this chapter the methodology will be discussed by accentuating four areas: (a) the qualitative method selected; that is, grounded theory; (b) the research design; (c) issues of rigor of the study; and (d) ethical considerations.

Grounded Theory

In this study the researcher used a qualitative research method called *grounded theory* as developed by Glaser and Strauss (1967). Using this method, the researcher investigated the dynamic social psychological processes that women pass through as they try to achieve closure of their abortion experience. When a dynamic process is being investigated (Morse & Field, 1995; Strauss & Corbin, 1990), where no theory exists, or when existing theory fails to explain adequately the phenomenon under investigation (Liehr & Marcus, 1994), the grounded theory method is the method of choice.

Grounded theory is founded on the theoretical perspective of symbolic interactionism, the underlying premise of which is that a person constructs meanings for a given phenomenon based on the interaction between self and society. This interaction is an ongoing process of symbolic communication (Chenitz & Swanson, 1986). Although a person's world might be perceived by others as disordered and nonsensical, the grounded theorist believes that the person has made order and sense of his/her reality (Hutchinson, 1986) according to his/her direct knowledge. Working from this assumption, the purpose of grounded theory is to generate new theory rather than to test existing theory (Glaser & Strauss; 1967; Morse & Field, 1995). The theory is grounded in empirical data

(Hutchison, 1986) collected from individuals who have had personal knowledge about the phenomenon under investigation (Morse & Field, 1995).

The goal of grounded theory is both to discover and to illuminate a basic social psychological problem and the basic social psychological process that resolves the problem (Glaser & Strauss, 1967; Morse, 1994; Morse & Field, 1995; Strauss & Corbin, 1990). In this study the fundamental aim of the grounded theory approach was to identify and explain all concepts pertaining to the underlying social and psychological forces that shaped the women's coping patterns in the resolution of the abortion experience. Although the theory is always grounded in the data collected from the studied participants, different researchers might generate different yet equally plausible theories while analyzing the same data (Glaser & Strauss, 1967; Strauss & Corbin, 1990). This difference in generated theories is explained by theoretical sensitivity (Glaser & Strauss, 1967).

According to Strauss and Corbin (1990), *theoretical sensitivity* refers to the personal ability of the researcher to develop insight from the data. Depending on this insight, the researcher gives meaning to data and understands and illuminates the pertinent features of the information elicited from participants (Strauss & Corbin, 1990). Theoretical sensitivity is developed through several avenues, including (a) professional and/or personal experience with the phenomenon under study, (b) research literature concerning the phenomenon under scrutiny, and (c) ongoing interaction with the data during data collection and data analysis (Strauss & Corbin, 1990). In addition, the researcher gains theoretical sensitivity by keeping a balance between scientific and creative development of the theory. According to Glaser and Strauss (1967), the researcher's ability to use judiciously personal and professional experience as well as the literature represents the creative aspect of grounded theory.

Research Design

The research design of this study will be discussed under three topic headings: (a) the sample, (b) data collection, and (c) data analysis.

The Sample

The sample of this study will be discussed in terms of theoretical sampling, the recruitment of the sample, sample size, and sample characteristics.

Theoretical sampling. When using grounded theory, the researcher recruits participants who meet the informational needs of the study (Morse & Field, 1995) to test ideas and gather thorough information about developing concepts (Liehr & Marcus, 1994). Selecting participants on this basis is referred to as *theoretical sampling*. Using this type of sampling, the researcher strives to select participants who possess three qualities of a "good" informant: (a) knowledge of the phenomenon being investigated by virtue of direct experience, (b) ability to reflect on this experience, and (c) willingness to share personal experiences with the researcher (Glaser & Strauss, 1967; Morse & Field, 1995).

The underlying canon of theoretical sampling is that the selection of the participants and the data analysis occur simultaneously (Sandelowski, 1995; Strauss & Corbin, 1990). In this process data analysis guides the selection of future participants who are believed to enhance the development of the theory (Glaser & Strauss, 1967; Strauss & Corbin, 1990). Participants are also selected on the basis that they are not equally informed about the knowledge sought by the researcher (Morse & Field, 1995). Sampling that is based on the theoretical needs of the study promotes maximum data variation and data meaningfulness, ensuring adequate data saturation for theoretical completeness (Becker, 1993; Glaser & Strauss, 1967; Morse & Field, 1995; Strauss & Corbin, 1990). In this study the researcher adhered to the above canons and assumptions while selecting the sample.

Recruiting the sample. After obtaining ethical clearance from the University of Alberta Nursing Ethics Review Committee and a Canadian hospital site, the researcher began recruiting participants for this study through personal contact, media advertisements, and social networking. With the support of the thesis supervisor, the researcher gained access to three agencies that carried out abortions. After personal contact and discussion of the study with the managers of the above agencies, the researcher obtained permission for personal contact with their clients, placing posters (Appendix A) and distributing information letters (Appendix B) in the waiting rooms to explain the study. At one agency the researcher discussed the study with approximately 40 women who had just had abortions or had visited the clinic for their follow-up appointments. Another agency also added the information letter to the package of information that had been given to approximately 200 women after their abortions were completed.

Posters were also placed in other locations such as women's changing rooms in recreational facilities such as SPA Lady, a health clinic at a university, and one physician's office in the inner city. In addition, to obtain access to low-income women, the researcher contacted in person the representatives of a community service center in a low-income district. Upon their invitation, the researcher participated in a meeting with approximately 60 women who represented the less-advantaged population. Prior to this meeting, posters (Appendix A) and information letters (Appendix B) were placed at the entrance to the meeting room. The researcher also attended a provincial women's conference and placed posters and information letters in a hallway of the meeting place. Finally, with the permission of the manager, the researcher placed a poster (Appendix A) in a local bookstore. As a result of the above advertisements, only two participants were recruited: one through the Women's Health Program and another through the bookstore. Ten participants were recruited through social networking. Thus a total of 12 participants were engaged in this research study.

As anticipated, prospective participants indicated their interest in the study by contacting the researcher by telephone. When the researcher was unable to answer telephone calls, potential participants were able to leave a message on an answering machine. The phone number, which included voice mail, that was placed on the advertising material was exclusively for the researcher's use. The researcher contacted prospective participants immediately after listening to their messages on the answering machine.

During the initial conversation, the researcher ascertained whether the callers met the inclusion criteria. For this study the inclusion criteria consisted of four points. The participant had to (a) have had an abortion at age 18 or older, (b) speak fluent English, (c) be willing to share her experience with the researcher, and (d) be able to commit the time to be interviewed within the metropolitan city where the study was conducted. After ascertaining the prospective participant's eligibility for the study, the researcher described the options of participation (these are described under *Data Collection*). Once the prospective participant chose her option, the researcher read (as per the caller's request) the information letter explaining the study (Appendix B). Next, arrangements for the first interview were made. Eight of the 12 participants preferred to discuss the details of the study by telephone and meet with the researcher once for an interview. The remaining four participants met with the researcher, discussed the details of the study, and arranged a mutually convenient time for the first telephone interviews.

Sample size. Taking into consideration the large volume of verbal data that must be analyzed, the intensive and prolonged contact with participants, and the high cost of data collection, the sample size in qualitative research is small (Morse & Field, 1995; Sandelowski, 1986; 1995). It is also difficult to estimate the sample size before commencing the study because sampling continues until major categories emerging from the data are explored and saturated (Glaser & Strauss, 1967; Strauss & Corbin, 1990). Data saturation is accomplished when participants share with the researcher repetitive information and when, despite the inclusion of additional participants, new ideas are not elicited (Morse & Field, 1995).

To meet the requirements of data saturation, the selected sample for this study consisted of 12 rather than 7 women as the researcher initially anticipated. Of these women, 9 were primary participants from whom the data were collected for the purpose of generating theory. The remaining 3 women were considered secondary participants from whom the data were collected for the primary purpose of validating the generated theory.

Sample characteristics. In qualitative investigation, to meet the theoretical needs of the study, the researcher identifies and invites the participants who can best inform the research (Morse & Field, 1994). As a result of theoretical sampling, the participants who shared their experiential knowledge about coping with the abortion experience presented with different demographic characteristics. To orient the reader to the research sample, demographic data were systematically collected by using a Demographic Data Collection

Sheet (Appendix C). Only aggregate information is provided to maintain the anonymity of the participants.

During the time of the study, all of the participants but one resided in a western Canadian metropolitan city. All participants were White, professional women. The age of the participants at the time of abortion ranged from 18 to 32, with a mean of 25.9 years. Compared with Statistics Canada for 1975 to 1993, the sample was representative of women aged 25 to 29 with the third highest abortion rate per 1,000 women of childbearing age (Millar, Wadhera, & Henshaw, 1996). In 1993, for example, the abortion rate for this group of women was 19.5, followed by the second highest abortion rate (21.5) among women aged 15 to 19, and the highest abortion rate (30.9) for women aged 20 to 24.

At the time of data collection, the number of years since the participants' abortions ranged from several months to 35 years, with an average of 16.3 years. The participants also varied on childbearing history. For example, 67% (n = 8) of these participants had no previous children at the time of their abortions, but 42% (n = 5) had children after the abortion. The remaining 33% of the participants (n = 4) had from 1 to 3 children before the abortion, and only one of them had a child after the abortion. Of the total sample, 25% of the participants (n = 3) had no children before or after the abortion. One of the participants adopted a child prior to her abortion, and two other participants were adopted themselves at an early age. As in Robson's (1985) study, none of the participants considered adoption as a viable option. Educational levels of the participants included college (n = 5), baccalaureate (n = 5), and postgraduate degree (n = 2). The participants had varied religious backgrounds such as Protestant, Roman Catholic, Calvinist, and atheist. Two participants performed abortions on themselves, one procured a clandestine abortion, and another one obtained her abortion in the United States. Three participants obtained therapeutic abortions for medical reasons, and the remaining five participants obtained abortions on request.

Data Collection

In grounded theory methods, sampling, data collection, and data analysis occur simultaneously on a systematic and ongoing basis (Becker, 1993). Sampling and data-collection techniques are subjected to continuous modification to confirm or refute theoretical explanations emerging continually from the incoming data (Glaser & Strauss, 1967; Morse & Field, 1995; Strauss & Corbin, 1990). The combination of multiple data sources is a strategy that adds rigor, breadth, and depth to an investigation (Denzin & Lincoln, 1994; Sandelowski, 1986). When little is known about the phenomenon under investigation, the unstructured interview is the technique of choice (Morse & Field, 1995). For this study the researcher collected data from eight unstructured face-to-face interviews, five telephone interviews, and one focus-group interview. As an alternative, participants were given the choice of sharing personal diaries that might have been kept at the time of the abortion or writing them specifically for this study (Appendix B). However, none of the participants chose this option. Data obtained from formal participants were supplemented by information obtained from women who had just had abortions and volunteered descriptions of coping with certain aspects of their abortions, but who had declined official involvement in the study. Considering all literature as potential data (Liehr & Marcus, 1994), the researcher also used Estes (1995), and Huston's (1997) findings as supplementary data to explain and enrich two categories.

The interviewing process. Prior to beginning an interview, the researcher reviewed and explained the study to each participant. Next, both the participant and the researcher stated their expectations for participation in the study. After the participant's questions had been addressed, the researcher obtained the participant's written or verbal consent regarding her involvement in the study (Appendix D). Subsequently, the researcher invited the participants to begin telling their stories about the abortion experience by using an opening statement such as the following: "Women who have had an abortion may have had different experiences. I am interested in learning how it was for you. Please tell me the story of your experience in having an abortion."

Each participant determined the sequence of her story. All participants but one began their stories with the reasons for their abortions and described ways of reaching the decision to abort. Similarly, all participants ended their stories by reclaiming the reasons for and benefits from having an abortion.

To ensure natural and in-depth expression, the researcher allowed each participant to tell her story without any interference such as probing, asking for clarification, or explanation. The researcher listened attentively to the participant's story. After the participant finished expressing her thoughts and expressed willingness to answer the additional questions, the researcher asked her more specific questions aiming at a more thorough exploration of the coping themes. The researcher also asked specific questions to elucidate coping strategies with a particular aspect of the abortion experience, even though such questions were often answered prior to their being posed.

The interviews that were conducted either face-to-face or over the telephone lasted from 45 to 90 minutes (average, 60 minutes). At the end of each interview the researcher asked the participant the following questions: "Is there anything you would like to ask me? Is there anything else I should have asked you?" These questions resulted in three participants' elaborating broadly on coping with their abortion experience. Once the interview was completed, the researcher collected demographic data (Appendix C). The researcher tentatively closed each interview with the participants. Tentative closure allowed the researcher the option of contacting the participant later to gather additional information or to verify data. At the end of each interview the researcher determined the participant's willingness to attend the focus-group interview. Upon request, the researcher discussed with several participants the focus-group interview in detail, including the risk involved. Initially, five women verbally agreed to participate in the focus-group discussion.

Although the researcher intended to interview primary participants twice, only one participant was willing to be formally interviewed the second time. The remaining eight participants declined participation in the second interview, claiming that they had already exhausted the description of their experiences during the first interview. This claim was confirmed by the repetitious information these participants offered during the focus-group interview or informal telephone conversations. These anecdotal conversations occurred around verification of the data collected from the previous interviews and confirmation of the emerging theoretical concepts.

To provide clarification and verification, the researcher asked the following questions: (a) What coping strategies did you employ as you were going through your experience that you would like to tell me about? (b) Are there any coping strategies you wish you had employed to help you go through the experience? (c) Some women find it difficult to carry out their decision to abort. How was it for you? (d) Some women keep their abortion a secret. What do you think about this? (e) Some women experience and grieve over the losses associated with their abortions. What is your opinion about this?

Once a conceptual framework had been developed through data analysis from the individual interviews and the focus-group interview, the researcher sought validation from three secondary participants. In addition to a validating discussion, these validating interviews contained elements of the interviewing format as described previously. The interview usually concluded with the validating discussion, which centered around the theoretical concepts. During the validating interviewing process and anecdotal conversations with participants, the researcher maintained flexibility in addressing specific questions. Therefore, some questions directed at validation were asked at different points of the interview depending on their fit into the context of verbalized data. The validating discussion was facilitated by asking secondary participants questions such as (a) Some women find it difficult to carry out their decision to abort. How was that for you? (b) Some women keep their abortion a secret. What do you think about this? (c) Some women experience and grieve over the losses associated with their abortions. What is your opinion about this? (d) For some women, coping with the abortion experience can be enduring. What do you think about using a metaphor such as "climbing a tree" to capture these efforts?

Focus-group interview. A focus-group interview can be used at any stage of the field investigation process (Fontana & Frey, 1994; Frey & Fontana, 1993) as complementary to individual interviews (Frey & Fontana, 1993; Krueger, 1994; Morgan & Krueger, 1993). In particular, the focus group can provide important information on sensitive personal issues about which participants are reluctant to talk privately (Morgan & Krueger, 1993; Zeller, 1993). The group interview can be used for validation of data gathered previously through individual interviews (Frey & Fontana, 1993).

Following the completion of the individual interviews, one focus group composed of three primary participants was conducted. This interview lasted 90 minutes. Despite their initial agreement to participate, two other participants, including a new informant who had not been interviewed previously, decided to remain absent from the group interview. The purpose of this technique was to confirm the analysis of data from the individual interviews and to explore the questions arising from the analysis.

An important contribution of a focus group is to provide a broader spectrum of data (Bash, 1987; Frey & Fontana, 1993; Krueger, 1994; Morgan & Krueger, 1993; Morse & Field, 1995); therefore the data were analyzed from this perspective as well. During the focus-group interview, the significance of social comparison was illuminated by the participants' unintended therapeutic interaction. Although the data were repetitious, the researcher gained new insights into the importance of social comparison in bringing closure on the abortion experience. Together, the individual and the focus-group interviews allowed the researcher to obtain data from the personal and social context that richly described the nature of coping with the abortion experience.

Two weeks before the focus-group interview, the researcher contacted (via telephone) five women who previously had expressed interest in participation to confirm their willingness. Upon mutual arrangement of a time 12 days before the focus-group session, a personalized invitation was sent to five participants (Appendix F). At the beginning of the focus-group interview, the researcher obtained written consent (Appendix E) from each participant.

The key role that the researcher played during the focus-group session was that of moderator. As the moderator, the researcher assumed responsibility for creating a tolerant, friendly, and supportive atmosphere that encouraged the participants to share their thoughts and ideas. The participants were provided with such courtesies as refreshments and beverages to facilitate relaxed focus-group interactions. As consistent with Krueger's (1994) suggestion, group interaction was initiated as follows: (a) a welcoming introduction, (b) the ground rules, (c) a graphic and verbal presentation of the conceptual themes theorizing the process of coping with the abortion experience, and (d) a broad opening statement, followed by the first question:

> What I would like is to have you comment on these findings so that I am able to evaluate my comprehension and, if necessary, make corrections and adjustments to my theory. This in turn will bring enlightenment to the real picture of coping with the abortion experience. How do these findings relate to your ways of coping with your experience?

Prior to these comments, the researcher expressed support for a diversity of ideas that would contribute to a better understanding of coping with the abortion experience. Respect for different opinions facilitated open communication and spontaneous, interactive group discussion. Although overdisclosure might occur when taboo topics are discussed in a group setting (Morgan & Krueger, 1993; Zeller, 1993), this situation did not become a concern. The researcher's involvement in group discussion was limited to using several probes including silence (waiting), neutrality ("Hmmmm . . . ummmm"), clarification ("I don't quite understand"), and confirmation ("Are you telling me that . . . ?"). In addition, the researcher observed the participants' emotional expressions and the interaction with the interviewer and among themselves. The researcher kept a record of the speakers' names and all events that occurred during the focus-group discussion. As Morse and Field (1995) suggested, such observation added breadth to the interview and linked the answers within the context of interaction triggered by the question.

All of the interviews including the group discussion were audio-recorded, and the tapes were replayed. Soon after, the researcher listened carefully to the content, questions asked, and participants' responses. A copy of each tape was made so that if the original tape was accidentally damaged during the process of transcribing, a back-up was available. Next, each tape was transcribed, the transcription was checked against the tape for accuracy, and the transcript was corrected if required.

To supplement the data density from the taped interviews, fieldnotes were written immediately after each interview and after the focus-group discussion. These fieldnotes described the context in which the interviews had been conducted. For example, such contextual elements included (a) the time that the interview began and ended, (b) the location of the interview, (c) interruptions that took place during the interview, (d) the emotional responses of the participants, (e) the content of the interview, and (f) the researcher's impression of content, depth, richness, and accuracy of the data. Such fieldnotes were useful in identifying ideas about relationships within the data and in providing a beginning cross-check for later analysis.

The interview settings. The researcher aimed to conduct the interviews at a time and in a setting that were both convenient and comfortable for the participants. Therefore, the researcher allowed the participants to decide the time and place of the interviews. In response to the participants' requests, five interviews were conducted in the participants' homes, two in a classroom at the University of Alberta in the Faculty of Nursing, and one in a cafeteria. The five remaining interviews were carried on over the telephone located at the researcher's office. During the study this office and the telephone were used exclusively by the researcher.

The interviews that took place at the participants' homes were held either in the kitchen or in the living room, depending on the preferences of individual participants. Sitting around the kitchen table or in the living room and drinking coffee or tea contributed to a relaxed atmosphere for the interviews. When two participants were interviewed, their children stayed at home. Loud conversations, laughing, or crying interfered with the audio-recording of the interviews and caused some tension in the participants. Greater problems with audio-recording were encountered during the interview in the cafeteria.

The data collected in two interviews that were conducted at the University of Alberta in the Faculty of Nursing were comparable to data collected in the home settings. Similarly, the researcher noticed no significant difference between face-to-face and telephone interviews in terms of quantity and degree of details contained with the data. The focus-group interview was conducted in a classroom at the University of Alberta in the Faculty of Nursing. The room was neutrally decorated; there was no outside noise that could interfere with the group discussion and audio-recording. While sitting in soft armchairs around the table and enjoying refreshments, the participants appeared comfortable and relaxed.

Data Analysis

In the grounded theory method, data collection and data analysis are conducted simultaneously throughout the duration of the study (Glaser & Strauss, 1967; Morse & Field, 1995; Strauss & Corbin, 1990). In these concurrent processes, data analysis guides data collection by using theoretical sampling (Becker, 1993). The researcher's constant dialogue with the data, in an inductive and deductive manner, was carried on throughout the process of simultaneous data collection and analysis. The inductive processes included coding, constant comparative methods, memoing, and sorting; whereas the deductive process involved the ongoing selection of the sample determined by the need arising from emerging analysis.

Coding. Data collected in the focus-group interview and individual interviews were analyzed in the same manner. The researcher started the data analysis by reading through each transcript carefully to obtain an overview of the transcript content. The main themes contained in the transcript were identified and recorded in descriptive memos. Next, the researcher used open, axial, and selective coding to analyze the data in depth. Open coding is used to identify the basic categories and to define their basic theoretical properties (Morse & Field, 1995; Strauss & Corbin, 1990). The researcher began open coding by reading each transcript line by line. During this process the incidents or facts contained within the data were identified. To facilitate identification of incident/fact, the researcher asked questions such as "What is this?" and "What is happening here?" Once identified, each incident/fact was given a code label. These codes, which were often the exact words used by the participants, or phrases that described the actions were written in the right-hand margin.

Open coding resulted in a large number of codes, labels, or concepts. Through the process of constant comparison, similarities and differences were distinguished between the code and conceptual labels. Similar codes/conceptual labels were grouped into a higher-ordered concept called a *category*. As a result, the large number of conceptual labels were reduced in number. In open coding, constant comparison occurred between the code/conceptual labels identified in (a) data collected within a given interview, (b) data collected in interviews with individual participants, and (c) data collected in the focus-group interview.

Axial coding condensed all open level codes and moved the data to a more abstract level. At this level, the fractured data in open coding was put back together by making connections between categories and their subcategories. By asking questions of the data (why? what? when? who? where?) while reading and rereading the data, the researcher recognized the cause, context, intervening variables, and consequences of the category.

In selective coding a network of conceptual relationships that have been identified during axial coding was sorted out and refined. Categories, along with their properties and dimensions, were grouped together according to discovered patterns. Thirteen categories and subcategories were condensed into four major areas: “Surviving,” “Healing,” “Becoming Whole,” and “Reaching Out for Support.” Through rigorous conceptualization and further consultation with the participants, the core category, “Restoring Wholeness,” was identified. Developed through this core category, evolving empowerment constituted the basic sociopsychological process (BSPP) that helped the participants go through the various stages and phases of the process of restoring wholeness. Hypothesized linkages among categories were confirmed through the process of ongoing rereading of the data. Linkages which did not receive confirmation from the data were modified. By testing and modification, the relationship between categories was further developed into a conceptual framework. To obtain a clear picture of relationships between all categories and their subcategories, the researcher diagrammed her analytical scheme of emerging theory. A model depicting the sequential stages of the process of restoring wholeness that explained coping with the abortion experience was described.

Coping with the experience associated with an abortion emerged as an enduring experience resulting in personal growth. To capture both the essence of this endurance and personal growth, the metaphor “Restoring Wholeness—Tending the Garden” was used.

Memoing. Memoing, a critical part of the grounded theory process (Glaser & Strauss, 1967), was initiated with the data analysis following the first interview and ended with completion of the theory. In the initial stages of data analysis, the content of the memos was often descriptive. The researcher primarily described various events observed in the data. As the data analysis progressed, the memos became more analytical in nature. Analytic memos portray the researcher's ongoing processes of comprehending, synthesizing, theorizing, and recontextualizing involved in the investigation (Morse & Field, 1995; Rodgers & Cowles, 1993). Analytic memos contained information about insights gained during the process of data analysis and the rationale for all decisions made about rejecting or confirming the emerging hypothesis. Process memos depicted all decisions made regarding the conduct of the study; for example, changes in interview questions and rationale for potential changes. In addition, memos used to bracket the personal perspective helped the researcher identify and control her own biases, thereby affirming the neutrality.

Data Saturation

Saturation of the data was achieved by constant comparative methods of data collection and analysis, theoretical sampling, and memo-sorting. As well, negative cases were sought, and additional participants were interviewed to explain all variations and diverse patterns of the categories. Negative cases included those women who experienced difficulty in achieving closure. The researcher persistently checked the data for questions about the cause, context, and consequences of a particular code to obtain answers and accomplish a sense of closure (Morse & Field, 1995; Strauss & Corbin, 1990). When nothing new was learned from the incoming data because all forthcoming information was repetitious and already confirmed in the previous data, the researcher stopped the interviewing process. Then the researcher summarized the theoretical explanations, followed by further comparisons with related literature. Validation and verification of the emerging theory will be discussed in detail in the next section.

Data Management

Using the color-coding technique, the manual method for data analysis was employed. According to Morse and Field (1995), this is a fast method of identifying all data in which pieces coded for analysis can be traced to the original source; thus the data can be easily retrieved and resorted. One colored stripe was used for each participant and another for the interview and was placed on each page of the interview in the left margin.

Next, the researcher cut the significant passages from the interview, taped them onto a full-size format of paper, and put them into the folder assigned for that category. The contents of the folder were sorted by commonalties into smaller categories. Once the open coding and initial sorting were completed, the researcher stored the coded data in the computer and used the word processor to facilitated further sorting.

Rigor in the Study

The researcher's primary goal was to generate a theory that would accurately describe and conceptualize coping processes that lead to closure of the abortion experience. To accomplish this goal, the researcher addressed the issues of reliability and validity. To ensure reliability and validity of the study, rigor must be achieved. Rigor in the study is achieved when the study meets the following criteria: (a) credibility, (b) fittingness, (c) audibility, and (d) confirmability (Morse & Field, 1995; Sandelowski, 1986).

A qualitative study is credible and fitting when the research findings represent a true picture of the participants' reality (Morse & Field, 1995; Sandelowski, 1986). To attain this goal, the researcher aimed to collect relevant, comprehensive, and detailed data which would be representative of women's coping processes for bringing closure to their abortion experience. This objective was realized by selecting participants who possessed the qualities of a "good" informant to ensure accurate and detailed description of the coping processes that led to closure of the abortion experience.

The researcher aimed to elicit exhaustive data from the participants by using several strategies. Prior to data collection, each participant was informed that the researcher was a nurse. Chenitz and Swanson (1986) asserted:

> The nurse image . . . gains[s] the confidence of informants. People identify nurses with a caring, nurturing role. . . . People will talk to nurses and reveal to them content that may not be so willing to disclose to others. (p. 85)

When responding to several participants who asked the researcher questions about her own perspective on abortion, the researcher ascertained these participants' perspectives of respecting women's right to choose. Each participant was informed that the researcher was not associated with any health-care agencies related to abortion services, fertility control, or adoption. In addition, the researcher allowed the participants to choose a location which was convenient, relaxing, and comfortable. All these strategies contributed to the development of a trusting relationship which encouraged the participants to openly and honestly share their experiential knowledge.

The researcher conducted the unstructured interviews which allowed the participants to take a lead in sharing their stories. A conversational approach (Swanson, 1986) was maintained when additional questions were asked. By allowing freedom and following the lead of the participants, the researcher was able to obtain a clear picture of each participant's reality. Comprehensiveness of the generated theory was achieved by utilizing several avenues. In addition to one focus-group interview, the researcher interviewed 12 participants and sought negative cases to ensure variations in coping with the abortion experience. The researcher's preparation for each interview involved reviewing previous interview transcripts and memos. This approach allowed the researcher to identify themes that required further exploration and expansion.

During the data analysis, the researcher met with her thesis supervisor periodically to discuss concerns regarding the study and various aspects of the emerging theory. The researcher often developed new insights into the emerging constructs through discussion with friends and colleagues. Coded and analyzed separately, data collected from the focus-group discussion resulted in validation of the conceptual framework. The researcher also compared, clarified, and verified the data through anecdotal conversation with the participants. The framework was also validated by three secondary participants who confirmed the findings. Once generated, the theory was further reviewed and validated by three participants who recognized the coping processes as their own. In addition to validating the generated theory, these participants identified several areas of bias and expressed some discomfort with the previously discussed metaphor to capture the essence of coping. Based on the feedback received from these participants, the researcher made modifications to the theory. The emerging theory was also verified with related literature.

Fittingness of the study is demonstrated by the applicability of emerging theory outside the study situation (Morse & Field, 1995; Sandelowski, 1986). This applicability was confirmed by two women who had had abortions but were not involved in the research study. Audibility of the study is accomplished when any reader or another researcher can follow the progression of the study's outcome and understand its logic (Morse & Field, 1995). To meet these expectations, the researcher maintained comprehensive and clear descriptive fieldnotes, as well as analytic and process memos (Rodgers & Cowles, 1993).

Ethical Considerations

The central principles that guided this study included (a) protecting participants from any harm, (b) avoiding coercion at all cost, (c) honoring participants' trust, and (d) allowing participants to have complete control over their participation. A variety of strategies were employed to ensure the ethical conduct of this study. First, the researcher began the study after obtaining ethical approval from a University of Alberta Ethics Review Committee and the hospital site. Second, written or verbal (telephone interviews) consent (Appendix D) was obtained from each participant before commencing the interview. Similarly, a separate consent form (Appendix E) was obtained from each participant attending a focus-group interview. Third, before signing the form, the researcher gave each woman the time she needed to further consider her participation. The researcher began each interview only when a woman signed the consent and indicated to the researcher both verbally and through body language that she was comfortable with proceeding with the interview. A copy of the consent form was given to each participant immediately after she signed it.

During the consenting process, a consent form (reading grade level 7.3) was read aloud and discussed, and all questions were answered. Before each participant signed the consent form, the researcher ascertained that the participants understood the nature of the study, including the purpose of the study and the participation requirements. Each participant was aware that her involvement in the study was completely voluntary and that she retained the right to refuse participation. The participants retained the right to withdraw from the study at any time and without any consequences by stating their intentions, either verbally or in writing. Each participant was also notified that she could stop the interview at any time by stating her wishes to the researcher. The participant retained the right to refuse answering any question(s) and/or discussing any topic raised during an interview. Each participant was given the opportunity to ask questions concerning the study; all questions were addressed by the researcher. The participants were aware that the audio-recorded interviews could be erased at the completion of the study, should they wish. The participants were informed that the interview transcripts would be kept in a locked cabinet for seven years. Each participant was aware that with her permission, anonymous excerpts from the interviews might be used in written reports and/or verbal presentations of the study. Each participant was informed that such accounts of the study would not contain her name. Rather, a fictitious name would be assigned to her at the researcher's discretion. The participants were aware that the data might be used for additional research after their consent and further approval from the ethics review committee.

Additional measures were undertaken to protect confidentiality and anonymity. Only the researcher knew the names and telephone numbers of the participants. The signed consent forms were stored in a locked cabinet separately from the interview recordings and transcripts. The tapes and the interview transcripts were color-coded and kept in a locked cabinet that was accessible only by the researcher. All names were deleted from each transcript. Any identifying information (names, age, occupation, number of children) contained within the transcripts was erased and/or changed. None of the interview transcripts were read by people other than the researcher and her thesis supervisor. Participants who voluntarily attended the focus-group discussion could use fictitious names to protect their anonymity, but they chose to use their actual names. Due to the potential for recognition, the manuscript, written, and verbal presentations of the findings will identify the participants by fictitious names and changed demographic data. After completion of the study, tapes, transcriptions, and notes will be retained for seven years. Locked separately from the research material, consent forms will be retained for at least five years. Then all data and consents will be destroyed. As previously mentioned, the data might be used for additional research, but only after further ethical clearance is obtained.

The researcher was sensitive to the fact that the participants might be experiencing psychological distress because reflections upon certain aspects of the abortion experience could evoke emotions. Thus, prior to conducting the study, the researcher prepared a list of counsellors who were available to provide counselling services to any of the participants. Although the women were aware of this opportunity, none of them requested the list of counsellors. Several women experienced emotional discomfort during the interview. To ease their emotions, the researcher turned the tape recorder off, stopped interviewing, and explored the need for supportive counselling. Each of these participants consented to resuming the interview. Despite the researcher's concern, overdisclosure of personal information did not occur during the focus interview.

The participants were aware that they might not directly benefit from participating in the study. They did, however, find it helpful to share their stories with the researcher, as was exemplified in the following comments: "It's wonderful that somebody is doing something about this [issue]" (Amanda); "I hope it will be of value to others" (Yolanda); "We are risk takers, . . . to speak up and teach [other] people how to step out of themselves" (Sinead); hopefully, "it isn't that miserable an experience for [women] in the future" (Ashley); "You are the only person I've told about that" (Barbara); "It's very good to talk to you. Very good" (Paula).

CHAPTER 4

FINDINGS

The purpose of this study was to generate a theory that would explain the core process of coping with the experience of having an abortion. Twelve women participated in this study. The respondents were assigned fictitious names, and all personal information that could identify them was altered. Demographic characteristics of the women are presented in Table 1. After a summary of the context of the data surrounding the experiences associated with having an abortion, a detailed discussion about the stages of coping will be presented.

Significance of Choice

The unexpected pregnancies of the women studied placed them in one of the most difficult crises of their lives. Resolution of this crisis involved struggles for the women's own survival, and often for their families' survival, including that of their children. For some women, these struggles often required abandoning hopes and dreams that they had held. As Catherine, who had been through this difficult process, said: "Abortion is a very difficult issue, but then anything that has to do with life and death is [hard]." Catherine's statement is reflected as well in Nancy Huston's (1997) novel, *The Instruments of Darkness*, where she stated: "The greater part of human passion has always revolved around non-existing beings" (p. 266). One explanation why the practice of abortion has been traditionally surrounded by controversy might be because these "non-existing beings," although invisible, significantly represent the potential for life. Another reason for this controversy might lie in problematic agendas involved with gender politics. Sinead stated: "Anything the patriarchy cannot do itself is relegated to the underworld."

However, conclusions that emerged from the data give new insight into conceptions of abortion and the social implications of this practice. Based on the responses of the women, one might consider that abortion is an act of love, rather than the lack of love. It is a different kind of love, granted, but one that involves sacrifice of the imaginable child. This paradoxical kind of love involves protection of a newborn child

Table 1
Demographic Characteristics of the Participants

PARTICIPANT	AGE AT THE TIME OF ABORTION	NO. OF YEARS SINCE THE ABORTION	CHILDREN BEFORE THE ABORTION	CHILDREN AFTER THE ABORTION
Paula	32	35	yes	no
Barbara	24	25	no	yes
Sinead	28	32	yes	no
Yolanda	19	18	no	yes
Olivia	32	6	yes	yes
Bev	27	13	no	yes
Reka	32	19	yes	no
Amanda	23	0.3	no	no
Ashley	21	9	no	yes
Caroline	25	22	no	no
Christine	30	3	no	no
Catherine	18	14	no	yes
MEAN	25.9	16.3		

EDUCATION:	non-degree - 5 degree - 7

Cassandra, Chris, Monica, Tiffany - women who did offer some information but did not participate officially in this study from possible suffering due to insufficient parental love or inadequate socioeconomic resources, in addition to parental emotional unreadiness. Can one say that all women who terminate pregnancies are "selfish" or "cruel"?

Some thoughtful responses supporting the notion that abortion might represent an act of love rather than a means to avoid childbearing responsibilities were offered by Christine, Bev, and Catherine:

> The ultimate concern involved in the abortion decision, it's not just you, it's not just [for] yourself and what is going in your body. There [are] also other things [the quality of life of a newborn, and that of the family]. (Christine)
>
> Let's say I would [have] been forced, let's say, to keep the child. I don't think it would have been a good thing, because you think of the quality of life you can offer your child. From the fact that you don't want that child, I think it would be awful for the child after it is born. I really think that. (Bev)
>
> There's no way I could offer a child any kind of support emotionally, rationally, or with any kind of decent life. . . . I wasn't in any situation to offer this child a good home. (Catherine)

This kind of love comes from a woman's instinctual nature. A similar kind of love can be observed in the animal world. For example, a wolf mother kills her mortally injured puppy. This hard compassion is necessary to allow death to come to the dying. A pregnant woman might be driven by a similar motive when exercising the right to abort. Not finding a trusting place for a child in herself, or in the world as it is, she regards ending the potential life as offering the child a blessing. As expressed by the majority of participants, she knows that a child born of limited parental resources and socioeconomic constraints would be wounded.

However, the opinions of women such as Bev and Catherine, as well as those of many other participants, were not shared by members of their families. For example, Reka's partner's family thought that she "was evil, just totally evil" because she aborted a "child" that she could not sufficiently nurture. Similarly, Christine's choice was also strongly disapproved of by one member of her partner's family: "[She] thought [that] I had done a very bad thing and that what I did was wrong." Furthermore, Ashley was accused by her mother of "murder[ing] her grandchild." However, most of the women studied knew that there was nothing more cruel than suffering children. Because they could not find a satisfactory place for the child-to-be, they made the difficult decision to terminate the pregnancy. Despite the disgraceful allegations of some sectors of society or family members, these women exhibited a distinct level of awareness, vision, and courage. Clarissa Pinkola Estes (1995), in her book, *Women Who Run With the Wolves*, used the metaphor "the wild women" to describe women with similar attributes: "[The wild women] ha[ve] innate integrity and healthy boundaries . . . [and] remember who they are and what they are about" (p. 7); "She is the Life/Death/Life force, she is the incubator. She is intuition, she is far-seer, she is deep listener, she is loyal heart" (p.12).

A wild woman is like a bear mother who would withstand a predator to rescue her offspring. The wild woman would combat nature when "it was the wrong timing" or "it was the wrong person to have this child with" (Amanda), or "to be linked to [an uncaring partner] forever" (Ashley). The wild woman would refuse nature's call for motherhood when she is "positioning [her] life" (Yolanda); "is not mature enough" and "had no money" and "no skills" (Ashley); and had "no support" (Reka). This type of woman is at risk of being branded by the surrounding culture, or even "shunned by a family," thus "left alone, totally alone in the world" (Reka). Despite these circumstances, the wild woman has the ability to sustain and adapt to change. Similar to a gardener, she is "the creator, [and the] steward of her inner garden" (Sinead) in which she could grow, blossom, and "create seeds for tomorrow's garden" (Catherine) of the stronger Self. This core, cyclic process of restoration consists of three stages: (a) surviving the struggle, (b) beginning the process of healing: the "power of love," and (c) becoming whole. The basic sociopsychological process of evolving empowerment explained all variations in the coping patterns directed at restoring wholeness (Figure 1).

The Context of Coping

Knowing that "there [are] so many children out there that are unloved and unwanted" (Amanda), a pregnant woman not finding a place of love for a child either within herself or in the world makes a choice to abort. This choice often involves "willingness to sacrifice [the potential life] for the greater good" (Sinead) of rational truth.

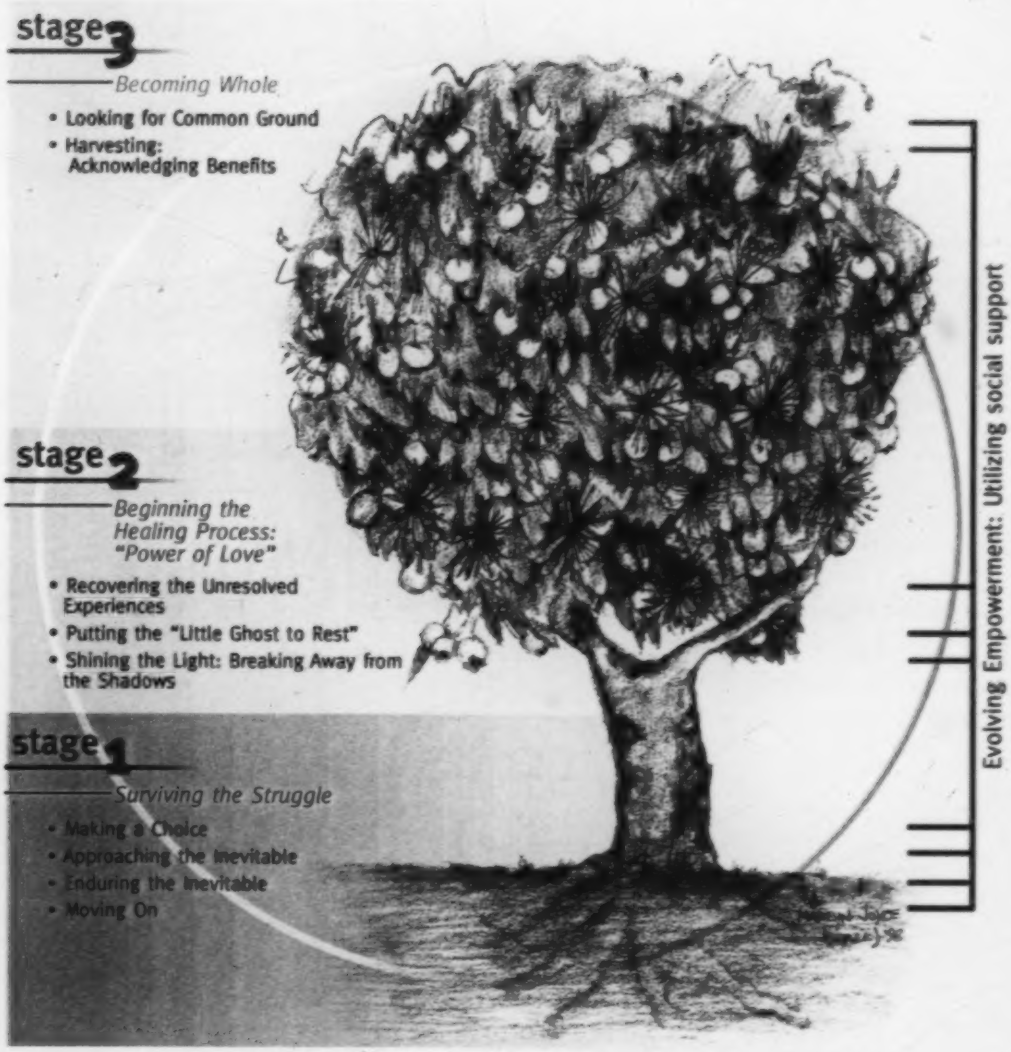

stage 3
Becoming Whole
• Looking for Common Ground
• Harvesting: Acknowledging Benefits
stage 2
Beginning the Healing Process: "Power of Love"
• Recovering the Unresolved Experiences
• Putting the "Little Ghost to Rest"
• Shining the Light: Breaking Away from the Shadows
stage 1
Surviving the Struggle
• Making a Choice
• Approaching the Inevitable
• Enduring the Inevitable
• Moving On
Evolving Empowerment: Utilizing social support

Figure 1. Coping with the abortion experience:
Restoring wholeness — tending the garden

All the women made an informed choice to terminate their pregnancies. That is, they were "informed about what will or will not happen in a rational approach to [experiential knowledge]" grounded in the context of their particular situations. To make a thoughtful decision, the women assessed thoroughly the stability of the relationship with their partners, their parental readiness including financial resources, and available social support. Following this appraisal, the women made the best choice they could make at the time for their well-being and that of their children-to-be: "It is a personal choice; it is a choice that you have to sit down and think and make on your own and decide what's best for you and that child at the time" (Amanda).

Depending on their family constellations, they created healthy boundaries for their own integrity and for their existing children. "This is a life-death decision and it's not quite simple. . . . It's a huge, huge decision" (Olivia). Similar to other situations where hard choices have to be made, the decision to terminate a pregnancy involves emotional pain: "It was a very agonizing decision for me" (Reka).

For the majority of women, the decision to terminate a pregnancy was a stressful and sometimes conflicting experience; "it was [a] tough decision, . . . although in many ways it was there." It was a tough decision to accept" (Yolanda). Uncertainty regarding the outcome of the choice might explain some of the pain involved in the decision. Correspondingly, right up until the last minute, several women experienced ambivalence about acting out the decision to abort. As Reka said, "There is no right answer; the thing is to figure out what your situation is, how you can deal with it, what your truth of reality is." Several women sought pre-abortion counseling to help them clarify or validate their decision. Other participants acquired knowledge about the implications of the abortion, but several others avoided learning what could impinge on their choice.

For Olivia and Reka, to whom pregnancies were considerably more meaningful than to the other women, the decision to terminate a pregnancy meant "an immense struggle." Unlike the other participants, both Olivia and Reka perceived the fetus as "a child" and originally desired to carry their pregnancies to term. Social support for motherhood, religious upbringing, and cultural proscriptions regarding women's sexuality caused additional emotional turmoil. Reka and Ashley, who previously held reservations about abortion, and Olivia, who initially intended to carry her pregnancy to term, were particularly affected. For example, Reka never contemplated that she would have to consider an abortion personally:

> I think before my own experience I had a feeling in the direction of anti-abortion—not that I would have legally prohibited anyone, but I would have never thought that I would have an abortion. I think that it has to do, I suppose, with profound feelings that come from the kind of [religious] upbringing I had. . . . So it was something [that] clearly I had a lot of ambivalent feelings [about]. I didn't think I would have to make a decision. I couldn't imagine a situation where I would have had to have an abortion.

Ashley stated: "[I found it] more difficult to make a choice than I thought. . . . I can't even remember if I had an opinion of it or not. I certainly don't think I really ever considered me [being pregnant], and what I would do [about it]." But unlike Reka, she encountered her difficulty arising from having "such a little support around" rather than from religious dogma. Similarly, for Paula and Sinead, Catholic upbringing had little impact on their choice. Their sense of desperation stemmed from the experience of already being single mothers and an inability to care adequately for additional children. These feelings were accentuated by lack of access to safe abortion services.

Even though the choice to abort sounds sensible on the "intellectual level," it is still painful to accept carrying out the decision on an "emotional level," as was expressed by Yolanda: "Logically, I knew it was the thing I had to do, but emotionally, . . . you get maternal, guilt. There's no doubt I felt it." Unattainable ideals emphasizing "motherhood" as a "gift" can complicate the decision-making process and, in particular, acting out the reasonable choice. Personal meanings of abortion "beyond the idea of choice" and "beyond the [purview] of medical procedure" further explained this inner conflict that created difficulties with acting out even the most responsible decision: "It isn't just a physical thing; you are getting rid of this tissue [from] your uterus; . . . it's a spiritual being, and at the time I don't think I really labeled it like that. It was more just something heavy in my heart" (Ashley).

In addition to maternal feelings and relatedness, emotions producing ambivalence about acting out the choice can arise from a body's physiological responses to its pregnant state: "Maternal instinct and the body are going to sort of err. . . . She is betraying her inner instinct. [She might feel] guilty over [going] through with the abortion" (Caroline); "For one thing you are still pregnant, and, physiologically, . . . your body is just taken bloody over. You know you can't go through with this [pregnancy, but] your body is saying, 'Hey, you are getting all ready here'" (Sinead). To reconcile the opposing voice coming from the "intellectual" and "emotional level" simultaneously, the women employed the following strategies: They reexamined their own and internalized values, they balanced the decision against their circumstances, and, finally, they accepted "the gray areas" surrounding the choice.

In this study one woman opted for a clandestine abortion, one chose an illegal abortion, and two performed the abortion on themselves. Three other women obtained therapeutic abortions as a legal necessity due to a medical condition, and the remaining five obtained abortions on request. All women participating in the study asserted that in terminating a pregnancy "it [is] a woman's choice to make that decision" (Amanda); "There are unique situations and times when a woman has to decide for herself; it's her decision" (Bev). Although strongly supporting the above perspective, the majority of participants desired to involve their partners in the process of making a choice. For example, Amanda contended that the choice, either way, should be made jointly: "It is her choice . . . if you are single, it becomes a we choice if you are married or in [a stable] relationship, . . . but if you are by yourself, it becomes a personal choice."

Whether the choice is made jointly, or by a woman alone, "women make the decisions for themselves—not to be influenced by the opinions of the other people around her in her life" (Ashley). Excluding Barbara, Sinead, and Paula, all nine women anticipated support from their partners to help them go through the process of making a choice. Four of those women did not receive any support from their partners. Reka's partner "would never take responsibility. He saw me alone as responsible, . . . that if I had an abortion, it was entirely my responsibility." As exemplified by Amanda, the other three women ended up making this decision by themselves "with no real support" from their partners: "He decided to walk away from it."

All participants, apart from Bev, commenced telling their stories by stating the reasons for procuring an abortion, followed by discussing the ways of arriving at the decision to abort. In contrast, Bev initiated her story by providing socioeconomic and political reasons to explain difficult living conditions for women and children in her native country. Taking into consideration the context and the sequence of each interview, the decision-making process appears to be a critical aspect of the abortion experience and its resolution.

However, "the whole issue of abortion beyond the idea of choice . . . is so critical" (Olivia), and "when the operation is over, the experience is not" (Reka). Making the choice, and subsequently enduring the procedure, constituted a milestone for the women's survival. The next step involved coping with the experiences associated with the abortion. Several participants experienced significant discomfort from the procedure due to nonsupportive, inappropriate, and judgmental treatment by health care providers.

Four of the participants responded to abortion in an emotionally distressed manner due to minimal or no social support in addition to insensitive treatment by health professionals. This distress was manifested in feelings of guilt, shame, low self-esteem, loneliness, and social isolation. For example, Barbara experienced low self-esteem because of violating family and cultural norms. Guilt occurred in Bev, Reka, Barbara, and Sinead from hiding the experience from their families. A number of participants expressed anger towards their partners, family members, health professionals, and society for supporting myths and expressing strong antagonism against abortion. Two women who desired to carry their pregnancies to term were coerced by circumstances into having an abortion.

The nature of social support appears to relate to women's responses and adjustment to having undergone abortion. Those participants who had a strong support system of friends (Paula) or family or who had obtained help from compassionate health professionals reported distinctively positive feelings and emotions: "It was absolutely the most relieving and happiest day [when] I could terminate those two pregnancies" (Paula), and similar feelings were experienced by Christine:

> To me it was a great relief because I wasn't ready for it at the time. So going through the procedure was, as I say, a great relief to me. When it was finished I felt so relieved that the people were very nice to me. I found all the nurses and [physicians] extremely nice to me, which was a lovely feeling. I felt supported, and also [they] made me feel more secure. . . . This was a great relief to me. . . . It took a load off my mind. (Christine)

All the participants considered the abortion experience as a loss: "the loss of a potential child," the loss of "part of myself," "the loss of innocence," the loss of "[who] I would've been," or change-related losses such as the "loss of relationship." Correspondingly, each experience involved grieving: "I think it's a grieving even though you've made the choice. This is what is right. You go through a grieving process" (Caroline). Depending on their social support, their emotional strengths, and the experiences associated with their abortions, the participants chose different paths to grieve their losses. Several participants started to grieve prior to their abortions. Most of these women cried the night before the procedure or said farewell to end the relationship with the fetus. In contrast, Catherine was "very quiet and very withdrawn and thinking about things, but there was no crying."

A variety of coping patterns were constructed by the women to cope with their losses and other painful experiences following the procedure. A minority of women continued to cry; several others avoided "dwelling" on the losses and the other experiences and concentrated on accomplishing their goals. Several other women "never discussed [the experience] with anybody," "shut the whole experience out," and "developed 'a mental block'" to gain emotional distance from the experience. Given the lack of social support, separating from the experience allowed these women to survive and to move on with their lives. Although this coping mechanism helped the women maintain an interrupted focus on their lives, it eventually produced emotional distress in them. Their buried painful feelings and emotions were channeled in dormant forms such as "depression," "haunting dreams," and "[detrimental health] habits." Similarly, the paradox of keeping the abortion secret as a self-protective yet shame-inducing mechanism was experienced by the majority of the women studied.

Later, significant life events aroused wistful recollections about the losses and unresolved painful experiences. At this time a majority of women recognized the need for grieving and the necessity for healing. The women indicated several catalytic events such as subsequent childbirth, "learning about early fetal development," "seeing a [small] child," the death of a family member, and retirement. The encounter with catalytic events inspired the women to move forward in the process from surviving to healing. The data indicate that grieving was an essential aspect of a cyclical process of healing. The dynamic nature of healing was clearly expressed by Catherine:

> Healing doesn't necessarily just last three months. . . . It is an ongoing [process]. . . . Healing depends on what kind of a wound you have in the first place. There are ragged wounds, and there are very simple punctures. There are wounds that get infected very badly, but there are also clean cuts.

Those women who received strong emotional support experienced "a clean cut" and healed fast from this wound. By contrast, those women who had weak or no social support had rugged wounds that became contaminated with shame and guilt. Social judgment and blame thrust many women into isolation with their secrets, resulting in increased feelings of guilt and shame. These women, in particular, needed more time to heal.

The women expressed their grieving and promoted their healing in various ways. Prior to the abortion procedure, several women said farewell to relinquish the relationship with the fetus. One woman addressed her grief along with her guilt by apologizing and asking the fetus for forgiveness. Two women developed rituals that provided a symbolic burial ceremony to validate and grieve their losses. Two others ventilated their ongoing or previously denied feelings in a ritual gathering. Two women experienced relief in writing about their abortion experiences. Finally, one woman expressed her feelings and emotions in art work. She also ended her relationship with "the little ghosts" by putting roses on the family grave.

Healing also was enabled by an empowering process. The women differentiated between their own feelings and emotions and those internalized from culture and society. They also explored the root cause of their negative feelings and emotions. By shifting the perception from the private domain of their experience to the cultural and societal, the participants attained a greater awareness of what caused difficulty with the experience. With increased awareness, the women challenged the myths surrounding the abortion. To cast off the shadow surrounding them, the participants reclaimed the responsibility and accountability for their abortions. In addition, they emphasized their authority to act upon their choices without the influence of others: "I found myself feeling a little bit angry towards the people who are against abortion. I [feel] as though they cannot gauge what's right for you" (Christine).

A self-enhancement strategy such as social comparison accounted for another essential tool in the women's journeys toward wholeness. By comparing themselves to other women coping with similar experiences, the women developed a sense of normalcy, self-acceptance, and compassion. In addition, the participants felt more fortunate in comparison to several different groups of women who were in undesirable life situations. By comparing themselves to a hypothetical woman coping with a "child dying at birth," a single mother, or young couples raising children without adequate financial resources, four of the participants felt more fortunate while dealing with the losses associated with their abortions. Five of the participants felt more fortunate when comparing themselves to other women who died or suffered from severe complications of clandestine abortions. Empathy, care, and compassion for other women going through similar experiences were the other outcomes of social comparison, resulting in deeper understanding of themselves and others. In turn, this brought about a positive perspective on their experiences and a sense of meaningful connection with the larger community of women.

By employing several coping mechanisms, all the women found meaning in their experience and put the abortion experience into a broader philosophical perspective: "It was my entrance . . . into the fullness of motherhood" (Olivia); "I gave up something for a reason, and the reason was, I wasn't complete, and I took the action to . . . make myself complete" (Yolanda). For the women, a sense of control over their lives denoted value in the experience. Although the participants procured an abortion to resolve their health crisis, the abortion experience nevertheless contributed to their personal growth. Correspondingly, the women recognized a variety of benefits from their abortions, such as "becoming a better parent," gaining "the ability to say no to children," developing "understanding and compassion," and becoming "independent" and "more assertive." A number of women developed greater appreciation for their ability to establish reciprocal relationships with others and to take better care of themselves. The women also acquired the "ability to make [informed] decisions and transfer [such skills] into different areas." For some women, saying "no" to unexpected motherhood was the first maternal decision, the first parental responsibility for setting healthy boundaries: "I learned that saying 'no' to [motherhood] was the right thing to do. . . . I [acquired] more ability . . . in my life as a mother to say, 'No, these are the boundaries on things'" (Olivia).

By recognizing the benefits of their experiences, the women acknowledged the empowerment granted them in their personal accomplishments while also developing a sensitivity toward others. Being empowered themselves, the women empowered others going through similar experiences. This strategy added to their well-being and to the comfort and confidence of others.

Social support, which included professional help, appeared to be a crucial factor in enhancing the healing process. The women attempted to find comfort from their families, friends, or counsellors throughout the entire experience. For some women, counselling provided the only outlet to avert negative feelings and emotions. For others, counselling broadened their existing support network, enhancing their well-being. Following the abortion, 6 of the 12 women requested counselling to facilitate exploration, expression, and clarification of their feelings and emotions.

Stage One: Surviving the Struggle

As the data show, an undesired pregnancy precipitated one of the most challenging crises of the women's lives. Resolution of this crisis involved struggles for the women's own survival and for the survival of their existing children. Once the pregnancy was terminated, the struggle to protect themselves from condemning judgments continued, leaving several women with limited opportunity for grieving and healing. The stage "Surviving The Struggle" (Figure 2) consists of four phases: (a) making a choice, (b) approaching the inevitable, (c) enduring the inevitable, and (d) moving on.

Making a Choice

To make an informed choice to abort is to become "informed about what will or will not happen in a rational approach to [a woman's unique circumstances]" (Catherine). In deliberating their options, the participants evaluated the need for care and responsibility for themselves, the expected child, and their existing children. This criterion epitomizes the intrinsic value of a genuine concern about dignity and quality of life. The participants

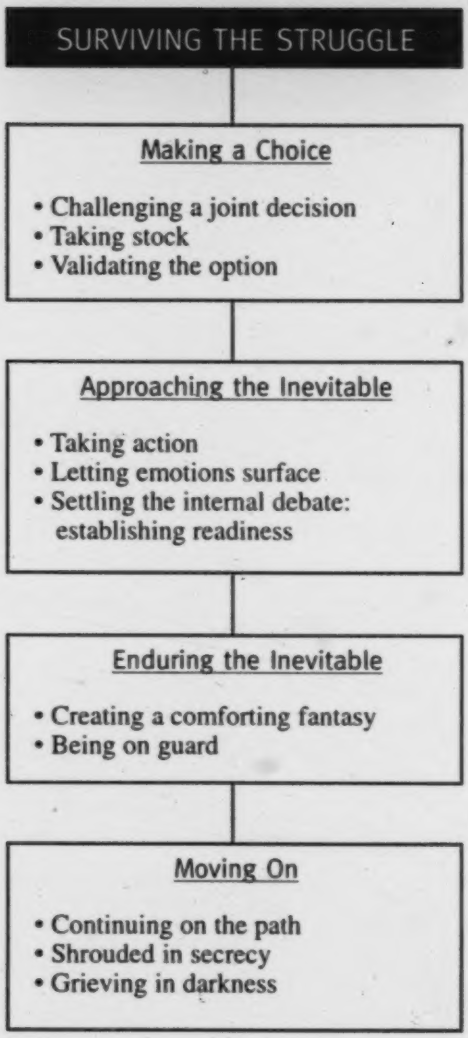

SURVIVING THE STRUGGLE
Making a Choice
• Challenging a joint decision
• Taking stock
• Validating the option
Approaching the Inevitable
• Taking action
• Letting emotions surface
• Settling the internal debate: establishing readiness
Enduring the Inevitable
• Creating a comforting fantasy
• Being on guard
Moving On
• Continuing on the path
• Shrouded in secrecy
• Grieving in darkness

Figure 2. Stage One: Surviving the struggle

demonstrated that they were guided by their moral responsibility to maintain and enhance their own and their children's quality of life. At the same time, they were also concerned about the quality of life of children brought into the world. Therefore, their moral approach was more pragmatic than idealistic. In the study the participants assumed responsibility for making a morally informed choice by employing a variety of strategies. These strategies are presented in the following sections: (a) challenging a joint decision, (b) taking stock, and (c) validating the option.

Challenging a Joint Decision

For the majority of participants, engagement of their partners in a joint decision-making process was considered important. This engagement provided the women with emotional support. As a source of solace, the emotionally present partners shared their point of view and showed interest in the women's well-being. They also acknowledged the women's feelings and emotions in addition to supporting them in their decision. By assuming joint responsibility in this "painful process," the partners reduced the stress and tension arising from the situation. They could also foster the women's confidence in their decision. As a result, the women experienced an increased sense of control and enhanced consciousness to make a more educated and rational choice. To involve the partners in a joint decision-making process, 9 of the 12 participants shared news of their pregnancies with their partners. In response, the partners of 5 of these participants assumed the responsibility of making a joint decision. The ultimate decision to terminate a pregnancy was, however, the outcome of the women's own conscious deliberations: "We agreed together to have [an abortion], . . . but . . . the decision was mine" (Bev). The partners of the other four women were also "very supportive of [their] choice" in a manner similar to the elaboration below:

> When I did become pregnant . . . I asked [my husband], "Is this something that you want right now?" I said, "I feel as though it's too early to bring a child into our new marriage," and he agreed. . . . This [was] the decision that my [partner] and I made together, and we felt comfortable about it. (Christine)

In contrast, Amanda, Caroline, Catherine, and Reka's partners declined to become involved in the joint decision-making process. For example, Amanda's partner "decided to walk away. . . . [She] ended up making the decision by [her]self with no real support from him." He nevertheless offered her support on the abortion day: "He said [that] he wanted to come with me [for the abortion], so I allowed that." Although, Caroline's partner "didn't want [her] to go through with a pregnancy, . . . as soon as he found out that . . . [she] was going to have the abortion, that was it; [she] never saw him again." Catherine's partner "only showed up when [the abortion] was finished." For Catherine, the partner's antagonistic interference in the decision-making process would have been more detrimental to her well-being than his withdrawal from such responsibility; it would have impeded her healing: "So it was my decision, and my situation. It was my healing—I had no interference. I imagine if I did, it would have been worse." Facing conflicting choices, Reka anticipated that her partner would be emotionally involved and would share responsibility in the decision-making process. However, her expectations were never met: "But he would never take responsibility. He saw me alone as responsible. . . . If I had an abortion it was entirely my responsibility. . . . At any rate, it was a very agonizing decision for me."

For some women, including Reka, it was important that their partners tell them their feelings about the pregnancy. For example, Reka, not satisfied with guessing, had to prompt her husband to tell her clearly how he felt about the possibility of having one more child. She "knew from his responses that he didn't want children; and, eventually, when I pushed him hard enough, he practically said, 'I don't want any more . . . kids.'" The partner's withdrawal from the decision- making process could be interpreted both as a disavowal of responsibility and as entrusting her to the process of soul-searching. Paradoxically, a partner's negative response towards pregnancy, even though painful, might bring about a positive outcome because a woman knows where she stands. Her partner's open expression about his feelings and his preference can be reassuring. Such reassurance can not only facilitate decision making, but it can also be reassuring in the years to follow. Yolanda validated this argument by stating:

> [The] father of the child, it took him until just a year ago to have his first child. I'm still in contact with him, and so children probably w[ere] something that he didn't want to do, and he stressed that, that he didn't want children, and I knew that.

The data also indicate that the partner's genuine response regarding pregnancy can also prevent a false sense of freedom in the women. A statement such as "Whatever; whatever you decide" can be as painful as total withdrawal from making the decision. Rather than offering required support, such a declaration imposes on a woman either total responsibility for decision making or an illusionary autonomy in decision making. This response does not necessarily demonstrate a withdrawal of support. It might, however, demonstrate inadequate support that is incongruent with the woman's emotional coping level. For Olivia, such reassurance as "I know this is your decision, and you know what [to do]," accompanied by "intellectual arguments," were fruitless, especially the night before the abortion, when her emotional struggle was heightened:

> He certainly, at that point, had seen my state. . . . I was very tearful. . . . Yeah, he sort of came around to "Oh, whatever; whatever you decide. I know this is your decision, and you know what [to do]." I think I know what he thinks and all that. Yeah, anyway he did try some intellectual arguments about the right way of weighing this and that, and it's just useless at that particular point. It's just really deep.

By contrast, the other three women participating in the study deliberately closed the door to discussion of the abortion. Paula withheld the news from her partner, knowing "somewhere deep that he was not going to be there," and she "didn't want . . . him [to be] scared and run away. . . . I loved him, so I didn't tell him." By her own conviction, Sinead assumed full responsibility for the decision-making process: "It never occurred to me to tell him. It was like it was my problem, and I had to do something about it." Barbara did not even consider assessing the partner's commitment to a child-to-be because she had "always felt he was kind of an alcoholic personality, and he tended to get into drug abuse, and I felt genetically that I didn't want to have anything to do with a child conceived in that manner." In retrospect, however, she believed that partners should equally bear all the consequences of an unexpected pregnancy, including shared responsibility in decision making:

> Even in the end . . . I won because it was my body. I felt like I had to make [the] decision [by myself], but also . . . I was the one who dealt with the pain of losing the pregnancy and going through all that trauma. . . . In so many ways we [allow] men [to] get out of this situation and take [the responsibility and the pain] upon ourselves.

Taking Stock

To make a responsible decision, each participant examined her partner's ability and commitment to becoming a responsible parent. In instances where partners were unwilling to share the responsibilities of raising a child, the women took stock of their own situation and ability to raise the child alone. They observed lives of single mothers and poor families to attain a closer picture of bearing parental responsibility without adequate resources. In addition, each participant weighed the responsibility of bearing a newborn against her past commitments and future goals. These strategies are discussed under the following subheadings: (a) surveying relational commitments, (b) scrutinizing personal needs and priorities, and (c) scouting ahead.

Surveying relational commitments. Although not explicitly stated, each participant fantasized about the ideal place for her child to be brought into the world. For Amanda, a child "deserves to have a happy, well-adjusted home; to have a mom and dad who love each other and care for each other in a way [that] a child can grow and be happy and blossom." As Amanda explained further, this happy home is not necessarily equated with a home built on traditional family values. It is "not [so] much out of wedlock but out of having a good solid relationship. . . . It was really wrong for me to have a child, and I felt really bad." Furthermore, each woman considered the possibility of shared responsibility for a newborn child's welfare and equal parenting as being requisite for bringing a child into the world. "I felt that I needed a commitment from my husband that he would be involved in taking care of this child" (Reka); "I guess I expected that he would be there" (Olivia).

For the women, their partners' commitment to raising a child-to-be and the stability of the relationship constituted the two criteria by which to decide how best to resolve the crisis of an unexpected pregnancy. Six of the 12 women embarked on an enterprise to explore the degree of their partners' commitment and the stability of the relationship. All the partners but one declined to share the responsibility for raising a newborn. For example, by revealing the news to her partner, Yolanda learned that "immediately there was no question in my fiancé's mind that he did not want to have a child at this point in his life." Likewise, Amanda "knew [that her partner] didn't want the child." She knew that her partner "was young and immature" and "not ready to make that choice, not ready to settle down and have a family." On the contrary, Reka had to prompt her partner to express his stance outright. However, he also refused childbearing responsibilities:

> I knew from his responses that he didn't want children, and eventually when I pushed him hard enough he practically said, "I don't want any more . . . kids." But he would never take responsibility. He saw me alone as responsible; that if I had an abortion, it was entirely my responsibility.

For Reka, her partner's commitment to raising the child was a paramount factor in considering the resolution of the unexpected pregnancy:

> When I realized I was pregnant I brought the topic up again, and because I had had a fairly difficult pregnancy and birth with [my second child] and I wouldn't have been able or willing to deal with another child, I didn't feel like I could do it entirely on my own.

Considering her partner's commitment to childbearing as paramount in providing a newborn child with quality care, Olivia divulged the news to her partner to assess his readiness for parenthood. Although her partner was initially overjoyed to learn about the pregnancy, later his enthusiasm faded. Like the other women, Olivia also learned that her partner would not be involved in parenting a child: "At first the news was greeted, . . . 'Oh, that's wonderful.' Suddenly the reality of things started to dawn perhaps mostly on him, and I guess I expected that he would be there." Similarly, Caroline resorted to abortion even though she "initially was very happy [about her pregnancy]." She thought: 'My God, I'm pregnant. Ahh.' However, her partner ostensibly discounted her pregnancy, and later he withdrew his commitment from the potential marriage. His "callous" responses toward her pregnancy and toward her choice accounted for the most difficult aspect of Caroline's abortion experience:

> He didn't want me to go through with this pregnancy, and I was flabbergasted because we had been contemplating getting married. . . . As soon as he found out that I was going to have the abortion, that was it. I never saw him again.

Ascertaining partners' unreadiness for assuming the parental role constituted the first difficulty that some women endured while deliberating their choice. That revelation acted as a guide in resolving the unexpected pregnancy. Discovering the partner's reservation towards pregnancy was painful, particularly for those women who connoted the fetus with "the child." For example, Reka considered her own health as a priority even though she perceived her pregnancy to be meaningful:

> I knew all along that [abortion] was a possibility; however, it wasn't a possibility that I wanted to take on, . . . but I felt that if I had [one more] child with no support from my husband, [caring for a newborn] would aggravate my depression.

In the beginning, Reka even resented the possibility of having an abortion: "I knew that was an outlet for me that my doctor would just whip me through and that the second opinion [would] just be a matter of showing up." Like Reka, initially Olivia was not expecting to have an abortion when she found out that she was pregnant:

> So it was quite devastating for me when I discovered that he just didn't think he could, that an abortion was the choice. I think that was really hard, the first hard piece I guess. That took a bit for me to come around to, at which point I couldn't say I was prepared to do that, but I did go through it.

After pondering relational ties, Ashley concluded: "I had a boyfriend, but it wasn't a very happy relationship." She was not considering a long-term relationship with her partner; therefore, she considered abortion a viable option to resolve a sad plight:

> I knew that I did not want to be with this guy, so that was another thing too. I felt like if I did go ahead with it [the pregnancy], I'm going to be linked to him forever, and I didn't want that.

Similarly, Amanda held a strong conviction that "you have children, you deal with them, but it's with a partner." Yet she ended the troubled relationship with her partner and deemed an abortion her choice:

> I knew it was my choice. . . . It was the wrong person to have this child with. I did not want this person in my life any more because so many secrets were hidden and kept behind a shield. (Amanda)

A similar reason was also expressed by Bev. She considered an abortion because of "some of the instability of our relationship. . . . We are not planning to marry. He said [that] for a long time" (Bev).

The knowledge gained from surveying relational commitments threw light on the women's prospect of rearing a newborn child alone. Based on that knowledge, women's options regarding resolution of an unexpected pregnancy became more apparent. Amanda suggested that women have three options regarding the resolution of an unexpected pregnancy: "There are three choices: There's abortion, adoption, and having [the child]." However, the data indicate that the women usually contemplated two options after determining their partners' unreadiness for sharing parental responsibility. These included an abortion or raising a child-to-be alone, whereas adoption either explicitly or implicitly was not considered an option by the participants.

Scrutinizing personal needs and priorities. Self-scrutiny of needs and priorities constituted the next strategy utilized by the women to make an informed choice. At that point the women focused their attention on ruling out the possibility of raising the newborn alone. That notion was clearly expressed by Yolanda: "Those were the only two options [adoption or abortion] that I was prepared for. I had already ruled out one. So it was just a matter of slowly gathering the information to rule out raising the child myself." By hearing the inner voice, each woman "just knew" that abortion was the only solution to overcome the crisis of an unexpected pregnancy. While grappling with the unique experiences springing from the unexpected pregnancy, each woman established her own moral agency to make an informed choice. For the women, appraisal of past commitments and future goals constituted the vantage point of ruling out single parenthood, thereby countenancing the abortion choice as the best option. For example, for Yolanda, Ashley, and Bev, education was one of the major concerns at that point in their lives. The impact of raising a child alone without adequate financial resources could play havoc with their plans for continuing education. Those concerns were clearly voiced in the following citations:

> Unfortunately, I still had a year left of school and I could see the impact of having a child now. I wouldn't have quite been done my education and that was a concern. (Yolanda).

> I was not married at that time. I was in university so my first concern was about my career I didn't want to be a burden on my family [by] having a child that I couldn't possibly raise at that time (Bev).

In addition, upon weighing pros and cons, Ashley came to understand that she lacked the parental skills and support necessary for providing care for a newborn:

> with this I remember I wrote down the list of what are the pros of . . . going through pregnancy, what are the cons of going through with it. It was so clear on paper, it made so much more sense to terminate it because I was at school, I had no money, I had no skills, I had no support.

Emotional readiness and strengths for rearing a child-to-be were other aspects of self-appraisal. For example, Bev believed that she could not have a child "from the financial point of view," but also she "really didn't think [she] was mature enough for this responsibility." Furthermore, concern for emotional maturity was also expressed by Amanda: "Neither one of us was ready at the time to make that choice of having a family."

> There wasn't a way for me emotionally to be able to have that baby and raise it on my own—I cannot give it the life that it needed. So my last choice was abortion, and it wasn't really a last choice either. I knew it was my choice when I first found out because it was the wrong timing for me. (Amanda)

Similarly, Yolanda, who "wanted children" in the future, felt she "just wasn't ready to have them at [that age]." Ashley's self-appraisal led her to the same conclusion: "I didn't even feel mature enough, like I had my own life together. I could hardly look after myself, let alone look after a baby." In addition, Yolanda facilitated her decision making by reviewing her already-established future goals and the impact of pregnancy on carrying them out: "Even my goals for life were not to have children until I was 30. That probably helped in making the decision as well in that you do have goals, and it just didn't fit."

Scouting ahead. Envisioning what it would be like to bear a child, what they could offer a child, or what they were doing to their children and their family comprised another strategy employed by the women to affirm their decision. The researcher used the metaphor of "scouting ahead" to embrace the women's approach to looking into their future life and the lives of their dependents to better understand the moral gravity of their decisions. By envisioning the impact of a newborn child on their lives, the women better understood the cost of rearing a child alone or without adequate support. This exercise reinforced their intuitive convictions that abortion was the best choice considering the context of their particular circumstances. Ashley "didn't want to be on Social Assistance and get in that rut." Although Ashley "was sure enough about the decision," she "did allow [herself] to wonder a little bit." She "walked around looking at the other mothers, pregnant women, . . . [wondering] what it would be like" to go through a pregnancy and have a baby. After the integration of subjective and objective knowledge, Ashley made the ultimate conclusion: "It wasn't the time to have a baby."

Although the women had already arrived at the decision to terminate their pregnancies, nevertheless, they still accrued more information to gain comfort in and support for their decisions. This view was supported by Yolanda's comments: "So it was a tough decision. Although in many ways [the decision] was there, it was a tough decision to accept." The women's abortion decision encompassed the desire to optimize the quality of their lives and those of their existing children. Additionally, the single and childless women desired to optimize future childbearing experiences.

The women participating in this study began to understand and accept their decisions to abort by reexamining two salient aspects of the decision. The first aspect embraced the self-preserving force that is human survival; the second concerned the quality of life of a potential newborn or their existing children. Concern for a newborn child was expressed by Amanda as follows: "It is a personal choice; it is a choice that you have to sit down and think and make on your own and decide what's best for you and that child at the time." Like Amanda, each participant considered the quality of life of a newborn child while deliberating over the informed choice to abort. Each woman, regardless of whether she had children or not, possessed a great sense of responsibility for bringing a child into the world:

> It's something that you have to think about because for the next 18 to 20 years that child is going to be by your side. That is something that you have to look after for the rest of your life. You are responsible for that person

> for the rest of your life. There [are] many things to think about financially, emotionally. You need the child. You need the support of your family and friends. (Amanda)

Some women pictured themselves with the child-to-be to illuminate that responsibility and to assess the internal and external resources necessary for carrying out the responsibility. For example, Amanda envisioned the impact of difficulties being encountered with raising a child without adequate resources. Thus, she could imagine the resentment and the frustration arising from the inability to carry out responsibilities associated with bearing a child. By picturing herself as a parent without support and adequate financial resources, Amanda envisioned bringing a child into a life of poverty. She feared that the resentment and frustration arising from intolerably difficult circumstances would be projected on the newborn child:

> If you don't, things can be taken out to a point where you are going to have regrets and take it out on a child, and that child does not deserve that. [The child] wasn't asked to be brought into that situation.

For several participants, understanding the experience of single parenthood either from personal knowledge or from the experience of others helped them rule out bringing children into the unwelcome world. For example, Olivia stated that, "knowing what being a single parent was like," she knew that she "couldn't manage another child on [her] own." The quotation below reveals Olivia's thoughts about coping with her decision:

> All mothers ought to face this decision seriously—that they are consciously going ahead or not going ahead with their pregnancy—to understand the gravity, the responsibility of being a mother. I hadn't done that with my first child; I just [got] pregnant: "I can do this. Yeah, and I can do it on my own," and kind of like that. . . . I hadn't really given it serious thought.

Yolanda, for example, gained profound insight into the gravity of responsibility regarding motherhood by envisioning the life of the poor. Based upon that image, the prospect of motherhood became pessimistic, and the choice to abort demonstrated thoughtfulness and moral responsibility:

> The other thing, too, I remember that helped me make the decision: When I was . . . to have the abortion I was waiting for the bus outside of the school. The school is across from some low rentals. . . . There [were] little

> kids playing along the side of the road in the puddles, and buses were whipping by. That was my sign, my thought: What kind of parent would I be at 20? What could I offer this child? Like I say, adoption was totally ruled out. In my mind it was abortion or raising the child myself. Those were the only two options that I was prepared for; I had already ruled out one.

Despite the fact that Amanda had not experienced single parenthood before, she could understand it by envisioning her future life with a newborn. Like Ashley, as previously mentioned, Amanda pictured her future with a baby by writing down the pros and cons:

> A lot of nights I just sat at home, I thought about it, I wrote a lot of things down on paper. I wrote out what the pros and cons of having that baby would've been. I wrote down along with the pros and cons what would be the good points and the bad points, compared to how my life would change, how that baby's life would be, the fact of me being a single mother and doing it all by myself.

Although not directly stated, by acknowledging the images of single parenthood—that is, raising the child alone without emotional and or financial support—the women regarded their abortion decision as an act of love and compassion for the unborn child. For example, Amanda foresaw that her situation and that of a newborn child would become more vulnerable both emotionally and financially:

> So I want[ed] better than that for myself, and I knew I could not give this child a happy home, a life it deserved, because I knew I would either be on welfare or I would be working like a dog and [not] getting the child the proper attention, care, and love it deserved.

The women who already had children scouted around for the welfare of the existing children. This constituted an additional coping strategy. These women considered abortion because of the desire not only to protect themselves and the unborn child, but also to protect their existing children from suffering. Paula and Sinead envisioned that their children could suffer from the social stigma that was attached to children being born of unwed mothers. Therefore, they considered abortion as a protective means in an attempt to safeguard the sense of themselves and the sense of both their unborn and their existing children:

> So when I realized that I was pregnant I panicked, just panicked, because in that day and age, here I was a single parent with three children who would also bear [the burden] that . . . their mother was pregnant and she wasn't married. . . . I didn't want them to suffer, [nor] did I. (Paula)

> I lived in a little rural town, and I was already a single mother of two children, and I think they were preschoolers. This was early in the '60s, so that single women in a small town with two little kids were [branded]. . . . It really would've impacted my whole family that was already there. (Sinead)

Today, societal rejection of children being born out of wedlock might no longer be as strong a concern for women facing an unexpected pregnancy. However, there were other considerations. For example, concern for children suffering from inadequate care and attention was an issue that the participants took into consideration to ease the process of decision making. Olivia's quotation portrays that coping strategy and illuminates the maternal love behind her abortion decision:

> I certainly was willing to go ahead and have this child, and then I kept thinking about the child that I had right then, and it just was really, really hard. Working full time and not having enough time to spend with her and to add another child to this; I just couldn't put it together.

By considering her own well-being and that of her existing children, Reka finally decided to end the potential life for the higher value of her children's lives. Nevertheless, "it was a very agonizing decision" for her "to end the life of the [unborn] child": "I felt that I already had two children and that if I had a third and no support from my husband it would aggravate my depression. I wouldn't be taking care of any of my children."

A working woman's day-to-day realities are also made more difficult. These days, there is little support for women expecting or already having children, especially those with inadequate education. For example, Chris (see Table 1) said: "I have a minimal chance to find a job with little education." Tiffany (Table 1) feared losing her job because of "taking days off when [her] children become unexpectedly ill [or when she herself felt] unwell during her pregnancy." Tiffany was also afraid of a "possible lay off when the pregnancy began to show or when taking [a] maternity leave of absence."

The women's decisions were governed by their moral agency being formed in the context of their particular experiences rather than by any abstract moral principle: To make an informed choice, "you can only work with what you know, and make the best decision based on [your personal knowledge]" (Christine). However, for some women the "decision was very difficult" (Yolanda); [it was an] immense struggle" (Olivia). The grounds for that struggle were explained by Bev and additionally exemplified by Yolanda:

> [When] I chose my option I didn't dwell too much on it; I just [went] with it. So, of course it was guilt, of course, all of this. I think it was from all your experiences you have, the cultural values, family, and government, although they didn't play such a big role. But my main concern was that I didn't feel responsible that I [could] take care of a child. (Bev)

> You'd still know what you're doing, and I still felt—you think that you could be having this child. You get maternal, guilt; there's no doubt I felt it. (Yolanda)

During this very stressful decision-making process, the women had to control their emotions to make a reasonable and responsible decision. Once the participants made the decision, they selectively sought various resources to validate their choice.

Validating the Option

After accepting the abortion decision, the women used two strategies to validate the chosen option: (a) selective approaching, and (b) selective avoiding. Selective approaching was aimed at pooling resources that would support the abortion decision and the decision-making process. This mechanism was comprised of several avenues: the use of social resources, selective "fact finding," and intuitive validating. Validation of the decision by their partners, family members, or friends appeared to be an important factor in fostering the participants' greater confidence in their choice. Six of the 12 participants could not obtain such validation either from significant others or from health professionals due to a lack of a support network. Five of the participants obtained support for their decision from their partners.

In addition to obtaining support for the abortion decision from the partners, the women sought validation of their choice from other individuals who were objective, resourceful, and supportive. Two participants' decisions were supported by their friends. Five of the participants sought clarification and validation of their decision from health professionals. Considering it beneficial, Olivia "went in there [the abortion agency] with my partner" to discuss with a health professional her decision and the feelings accompanying her option. Christine and her partner considered a joint appointment for supportive counselling to validate the decision and her feelings surrounding the choice: "I went myself—my [partner] was working—to the doctor and discussed his and my decision with the doctor and discussed my feelings with her." Although for Reka joint pre-abortion counselling focusing on clarification of her feelings surrounding her option was significant, she was unable to obtain such validation:

> No one ever said to me, "Well, . . . why don't you and your husband and I sit down and talk about [your decision], and make sure, is this what you really want to do?'" . . . No one searched my feelings; no one questioned.

As a strategy, selective "fact finding" focused on "gathering the information that made [the woman] feel more confident about what [she] ha[d] done to make the decision" (Yolanda). For example, Ashley "had already made [her] decision," and she sought support from a renowned women's agency to help her explore and clarify missing facts while validating the decision: "I just felt maybe I'm missing something, maybe I'm forgetting to consider something because this is the first time it's ever happened to me." Similarly, Yolanda contacted medical doctors to discuss the medical implications of having the abortion: "Would [the abortion] prevent you from ever having children in the future?"

In contrast, several of the participants avoided contacting those individuals who, by using Pro Life arguments or abstract moral principles, could counter their decisions The mechanism which I called "selective avoiding" of social resources was portrayed by Yolanda: "I didn't go to the Father of my church and ask his opinion because I didn't want to hear it." Caroline and Reka avoided seeking support from their mothers, who were "anti-abortion" and therefore could exert a negative influence on their decisions or contribute to already-painful emotions. Another mechanism, selective fact avoiding, was employed either simultaneously with selective "fact finding" or separately. As previously mentioned, Yolanda "focused on the effects of having an abortion" to find an answer to a selected health problem, while setting boundaries on "the knowledge that [she] received at the time." This strategy prevented her from evoking painful emotions:

> So when I did my research in determining whether or not I wanted to, it was more [the] physical that I looked at. I didn't even consider looking at this child as a human being. I didn't even touch on that aspect of it. I guess "what you don't know [doesn't] hurt you" was probably the attitude I had towards that.

To maintain focus on their choice, the other women also refused to be influenced by some abstract moral principle. Paula, Sinead, and Bev dismissed the potential learning that could complicate the decision-making process or cause perplexity between validating and acting upon the decision:

> So I think the panic of being pregnant and having it just put out of my mind and my heart any other considerations like "This is a child: Is it right? Is it wrong?" I just wanted one thing, and I wanted not to be pregnant. (Paula)

> So I was incredibly desperate. I could not think about what was going to happen to me for having had this abortion. I just knew that it had to be done; there was no choice. Period. (Sinead)

In contrast, Catherine responded to this moral challenge by learning about fetal development with full, conscious awareness:

> It was a display of the joys of childbirth, and there were bottles of fetuses in various stages of development that were in formaldehyde, . . . so right from the very smallest to the largest, and there was a whole series of them, and it was the real thing. . . . So I realized, This is something that I have to look at very carefully because of what I'm about to do. . . . [I gave] very careful consideration to what I was going to do, [and] I believe I made my peace with [what] I was doing and understood it.

Unlike Catherine, some women might deliberately avoid learning about this particular aspect of abortion to sustain emotional strength, preserve their energy, and save time. Therefore, they can maintain focus on what is significant to them while dealing with the abortion decision and "deal with this [issue] later when [they] can":

> A lot of women don't necessarily look at all of those aspects because they can't. They don't have the time, or they're not in a good emotional situation. They don't feel safe where they can take those things and examine them. They don't dare. They are scared.

For Sinead, intuitive validating in combination with the fact-finding mechanism was a way of gaining confidence in the decision and the courage to perform the abortion on herself. Although the abortion was the best alternative to an unexpected pregnancy, a lack of accessible safe-abortion services caused Sinead to question the chosen option. "Desperateness" from this situation produced emotional torment that precipitated suicidal thoughts in Sinead. Those alarming suicidal thoughts led her, however, to a survival-oriented revelation: "Jesus, you're going to die for an unborn child and leave these kids, and then I knew I had to do something." On the edge of survival, Sinead recognized that abortion was the only option:

> I didn't know what I was going to do, although I was sure that I wasn't going to have this child. I had never known of an abortionist. I had no idea how to get an abortion. Nor did I have any money, but I would have come up with the money, I knew that. And so I remember one day driving along in my car, and I actually started, found myself planning my suicide, and then I said, "Hey." I guess what I recognized then was that I was not going through this pregnancy, and so I was between a rock and a hard place. So I wasn't exactly a suicidal person, so that was a big shock to me when I woke up. So I just planned how it would be that I would steal equipment and I would do the abortion myself.

For Olivia, intuitive validating was the last coping mechanism that she used to support her decision. She recalled the "image of death being present," and upon reflecting on such an image, she came to terms with her decision:

> I had the sense of death being present in some way which I didn't comprehend at the time, but later I held on to that as maybe something bigger than me, I guess, having some sense of what needed to be. Again, this is all to do with how I came to terms with what I felt needed to happen or what was going to happen.

Approaching the Inevitable

Once the women made their decisions, they entered the next phase of the process, which encompassed booking appointments, coping with emotions, and establishing readiness to carry out the decision. As the data show, once the decision is reached on the "intellectual level," it calls for reconciliation on the "emotional level." For the women, this reconciliation created another struggle. This struggle with either their inner voices or cultural/social influences, or a combination of both, produced feelings of ambivalence. The women used several coping mechanisms to deal with a variety of issues arising from the approaching abortion. These are elucidated in the following sections: (a) taking action, (b) letting emotions surface, and (c) settling the internal debate: establishing readiness.

Taking Action

After understanding the weight of their decision, the women who had access to a legal abortion proceeded with the final steps to conclude their pregnancies. Those steps included reflecting upon feelings associated with the abortion and booking appointments for the procedure:

> As I say, I immediately took the steps to have the abortion. . . . I was probably 14 weeks because I did not have it until the middle of [month] because it took me so long. I had to do the fact finding, and it was difficult to finally book the hospital dates. That was the last step. (Yolanda)

> So I continued in the relationship with this man and kept talking about all of these emotions bubbling up, and I think somewhere between then and zooming ahead to the day before where I had to go. (Olivia)

Although a majority of the women received legal abortions, many of them encountered other obstacles to obtaining satisfactory abortion care. Often those obstacles involved confrontation with a delayed or a hastened procedure, judgmental attitudes, and myths surrounding motherhood. For example, Olivia "finally [made] the appointment," and she was "quite shocked to discover that [she] had to wait" until she was "about 13 weeks along." Conversely, Reka obtained an abortion before even being emotionally prepared for it. Depending exclusively on Reka's medical health history, a physician assumed that she "couldn't possibly be a good parent." She was then disgruntled because health-care providers ignored her feelings about her pregnancy, and her lack of readiness for the abortion:

> So I went, as I suspected, I mean basically I was sent to a Dr. [name] at the [hospital] who basically rubber stamped the abortion. And then I was scheduled . . . for day surgery. . . . I] wanted the child, but under the circumstances I couldn't go through it. So that bothered me for a long time, and because the medical people were very dismiss[ive].

Moreover, while visiting the doctor's office, some women were exposed to decorative elements that could either undermine their decision or make them feel guilty for proceeding with it. For example, while visiting a "doctor's office" to arrange the appointment for the abortion, Ashley was challenged by "all these baby pictures all over the walls." Given that the pictures depicted cultural enthusiasm surrounding motherhood, Ashley was haunted by such images in her dream:

> So I went home in the afternoon from that appointment very upset. He was a gynecologist/obstetrician, and I had an afternoon nap after that appointment. I had a nightmare about it, and I dreamt that I had given birth or something almost, or that maybe I had the abortion but there was a little fetus in a jar, and they were forcing me to name it. There were all these other ones along the wall, and I know distinctly that that [dream] came from seeing those pictures on the wall of the other babies, and that here I'm not going to have a baby; I'm just going to have a little, little—but I have to still give it a name. So they were all around me, saying, "What's the name? Choose a name for us." It was a really disturbing dream.

In addition, the same physician warned Ashley not to become a repeater by saying: "I want you back in here, and you're going on the pill." To challenge the situation in a constructive manner, Ashley deliberately put herself into the position of grinning and bowing to gain support and obtain an abortion. The quotation below echoes Ashley's particular coping strategy:

> I just felt at that time [that I was] jumping through the hoops. I don't want to continue this pregnancy, so I have to jump through all these hoops for people, and I have no power and I need something done and they have to help me, so basically I have to be nice and just, you know, go to all these different appointments and talk to these people, and then they will do the surgery. It was very humiliating.

The women who had no access to legal abortion services explored illegal access or procured a means to perform the abortion by themselves. For example, Paula "began then to count on friends who could find" an abortionist. Similarly, Barbara reached out to others for support to help her identify "a person who did abortions" in the United States. Realizing that their integrity was at stake, Sinead and Bev, who either had no friends or did not wish to involve them, created a means for self-induced abortion. Interestingly, these women represented two different continents and almost a generation gap at the time of their abortions; however, they used the same means to perform an abortion:

> So I went into [name] Hospital, and I stole a Foley length catheter. I knew if I could get a Foley catheter in, it would dilate. If I could get the cervix dilated, then I figured I would abort. (Sinead)

> When I chose my option I d[idn't] dwell too much on it; I just [went] with it. I had access to some medical means, so I used like [a] thin tube that you use for catheterization. (Bev)

Letting Emotions Surface

Once the participants validated the decision and arranged appointments for the abortion procedure, they allowed their emotions to surface. Until this phase the participants controlled emotions to avoid emotional influence on the decision-making and decision-validating processes. One explanation for the need to control emotions was offered by Ashley, who maintained control over her emotions in order to avoid jeopardizing her access to the abortion. Although feeling "very upset and angry" at "judgmental and belittling" physicians, Ashley made an effort to hold her emotions at bay by pretending to be pleased with the care she received.

The night before the abortion was a highly emotional time for a majority of the participants. One woman "was very quiet and very withdrawn"; others released their emotions through anxiety, fear, and crying. As exemplified by Christine's and Reka's personal accounts, these women released their emotions in response to expecting the unexpected. This strategy helped them maintain control during the abortion procedure:

> I was very anxious. . . . I thought [the abortion procedure] was going to be a horrible experience in regards to how [the health providers] m[ight] think of [me]. They might think badly of me, of becoming pregnant negligently, and I thought that the actual procedure was going to be very painful. (Christine)

> When [my friend] related the experience to me, it was exactly the same, the terror. . . . She was terrified of the abuse that would take place [during the abortion procedure]. She believed [that] she would be abused. (Reka)

Crying and insomnia the night preceding the abortion were reported by 3 of the 12 women participating in this study. However, in anecdotal conversations with approximately 20 women on the day of the procedure, the researcher found out that more than half of these women cried and barely slept the previous night. The prevalence of this behavior reported in both anecdotal conversations and in this study leads to the conclusion that crying seems to be a patterned phenomenon rather than a singular episode. Crying the night before the abortion procedure might signify one of the coping modalities for an emotionally tense experience.

In her book *Women Who Run With the Wolves*, Clarissa Pinkola Estes (1995) claimed that "tears make us conscious. . . . There is no chance to go back to sleep when one is weeping" (p. 437). Following Estes' assertion, crying might contribute to women's increased awareness of the inevitable end of a pregnancy. Subsequently, tears might increase awareness of one's fear and anxiety. For example, Barbara said that "the night before, of course I couldn't sleep at all. I was quite frightened. I had to go through the enema and all those procedures."

Furthermore, tears might enable a woman to feel her pain and to draw compassion for herself. For example, Estes (1995) argued that when "a woman cries the tear, she has come upon her pain" (p. 166). Similarly, Olivia "was very tearful" and "had just been crying most of the evening." She cried the tears of compassion for herself and the other, and for knowledge and relief: "[Tears] cause a soul to peer into what the soul truly wants, and to weep for loss and love of both" (p. 165). Likewise, "the night before [Yolanda] cried and cried and cried and cried. . . . I did not even know if I slept that night." As Yolanda stated, she cried the tears from the emotional pain being brought upon her from "a . . . rejection from the father, the sperm donator."

Estes (1995) declared, "Crying is good, it is right. . . . [Crying) does not cure the dilemma, but it enables the process to continue instead of collapsing" (p. 443). Correspondingly, the women in this study could utilize their crying constructively in the struggle with approaching an inevitable abortion. By crying the tears, they generated strength and energy, which enabled them to move forward along the chosen path. By crying the tears, the women let go of a great deal of emotional restraints and realized the power of choice. Viewed in such a way, crying used constructively in coping with the inevitable can be understood also as liberation. Such benefits of crying were exemplified by Yolanda in the quotations below:

> I was given at that point every opportunity to not have the abortion from the pain that I was in. My fiancé totally supported me going through with the pregnancy, yet I still got up and went to the hospital at six in the morning.
>
> I think by that point he was quite devastated and saying "Well, you know, we don't have to go through with this." There was a little bit out there for me, although I didn't feel he meant it at all. You know, he would not have been there.

Settling the Internal Debate: Establishing Readiness

A majority of participants had already accepted and validated their decisions prior to making appointments for the abortion procedure. However, this "life-death decision" was reached and reconciled by the women on an "intellectual level." The resolution of the crisis of an unexpected pregnancy was at stake. The intellectual level, or the "rational voice," aligned with problem solving, was involved in appraising the situation to bring about a workable solution to a crisis situation. The data from this study, however, indicate that the majority of the participants remained ambivalent about acting out the rational decision. For example, Ashley still considered the likelihood of retreating from carrying out the logical and reasoned decision:

> I invited a friend over one time, . . . and I said, "This is my decision. I'm going to have an abortion." [Then] I said, 'Why don't we go out and have a beer? I'm going to have an abortion anyway." . . . But when we did go out, I wouldn't drink because I just thought, "You never know. . . . If I change my mind, I don't want to [risk the fetus' development by] drinking."

As well, "the night before" the abortion constituted one of the "most intense moments," because often the "emotions take over" casting doubt upon acting out "the right decision." As the data demonstrate, the "emotional level" was another component of the women's coping process that played an important role in establishing their readiness for abortion. The rational voice, the pragmatic focus on survival, appeared to govern the decision-making process. In response to the threat posed by an unexpected pregnancy, this voice helped the women make a choice that would eliminate the threat. The rational voice also allowed the women to arrive at a thoughtful decision while stabilizing the "emotional level" or the emotional voice.

The emotional voice, focused on caring and relatedness, could run counter to the rational voice. These countering voices could cause turmoil and provoke painful reflections in some women, especially during the night preceding the abortion. That particular situation, and this demanding position in which several of the women found themselves, was echoed in Olivia's expression: "That whole night stands out in my mind; it just is an immense struggle." A parallel statement explains the nature of this struggle:

> [You are] in turmoil right up till the morning you're going to the hospital, and even then as you are lying there waiting you're still questioning: Is this the right thing to do? . . . I could intellectually see [that the abortion] was the right thing to do, [but] emotions t[ook] over, and that [was] where my difficulty lay. . . . I became emotional about it. (Yolanda)

Considering the context of this study, the conflict between the rational and the emotional voice was brought about by maternal feelings, the pregnant body, and twisted cultural messages surrounding motherhood. When a woman approaches the inevitable abortion, emotions evoked by maternal feelings and a biochemical connection with the pregnant body could remind her of the relationship between herself and the fetus:

The intellectual side told me I was doing the right thing, the emotional side is where I felt the guilt and the nurturing, and the excitement of potentially being a mother, all of those factors would have come in. (Yolanda)

> Maternal instinct and [her] body is going to sort of err. . . . She is betraying her inner [maternal] instinct, [so she might feel] guilty over having . . . the abortion. (Caroline)

> For one thing, you are still pregnant, and physiologically . . . your body is just tak[ing] bloody over. You know that you can't go through with this [pregnancy], [but] your body is saying, "Hey, you're getting all ready here; look at your breasts." How could you not be ambivalent? although I do not remember being ambivalent about either [of my] abortions. I was very ambivalent about both pregnancies; I mean, about keeping the child. (Sinead)

Being driven by the force for survival and the desire for a self-fulfilling life, including the existence of others, the women deliberately buried their relation to the fetus until the night before the procedure. Correspondingly, this conscious decision was made by the women to avoid additional emotional distress that could complicate their decision even more: "I just put out of my mind and my heart any other consideration. . . . It felt to me it was not a child" (Paula). At that particular time, the emotional voice embodying feelings and focusing on caring and relatedness might oppose the pragmatic voice of the intellectual level. As a consequence of this struggle, ambivalence and guilt were also states of mind experienced by the women. However, these feelings were also produced by cultural support for motherhood.

Seven of the 12 participants experienced mixed feelings about acting out the decision. For example, Bev asserted, "I think that all experiences in having an abortion involve also a lot of ambivalence in feelings." She explained her source of guilt by stating, "I felt guilty because, from my culture, we really love children." Following Bev's version, the culture's mixed voices might effectively penetrate a woman's soul, thus increasing her feelings of ambivalence, and often guilt. Furthermore, terminating a pregnancy can feel even more tragic if a woman has never considered personal confrontation with that predicament. Such a difficult position was experienced by Reka:

> I think before my own experience I had a feeling in the direction of anti-abortion—not that I would have legally prohibited anyone, but I would never have thought that I would have an abortion. . . . That has to do, I suppose, with profound feelings that come from the kind of upbringing I had; . . . I had a lot of ambivalent feelings. I didn't think I would ever have to make a decision. I couldn't imagine a situation where I would have had to have an abortion.

The internal debate pressuring a woman's decision to have an abortion, along with the cultural messages reinforcing motherhood in response to nature's call, might pull a woman's desire in two directions: yes/no, no/yes. Consequently, some women find themselves struggling with establishing harmony between these two voices, thereby allowing them to accept the responsibility for acting out their decision. To establish readiness to carry out the decision to abort, women "have to take the responsibility for the choice that [they] make, and that's the way it is. Part of accepting the responsibility [for acting out the decision] is the way of dealing [with the abortion]" (Catherine). To accept the responsibility for acting out the decision, "you have to know in your own heart and mind that you are doing the right thing for you[rself]. . . . [You need to be] content, as content as you can be" (Caroline). At the same time, "[You need to] stick to [your rational decision], not [to be] swayed by [the] sentimentality of the moment" (Sinead).

Although all the women were content with their choice on the "intellectual level," they needed to reconcile the emotional Self that produced "the ambivalence about the process [of acting out the decision]" (Reka). To reconcile the ambivalence in response to the abortion, the women settled the voices by differentiating their voices from the other voices in their culture. For example, Ashley recognized that the voice speaking mothering and motherhood that was inherent in her socialization process suddenly became foreign to her. Consequently, she consciously rejected the myth considering pregnancy as a gift and impending motherhood as an obligation. Ashley offered a palpable explanation for how she coped with her ambivalent feelings:

> [On an] intellectual level and on so many levels it was not a good thing [having a baby]. On another level I just felt really excited about it. . . . It's kind of like your whole life as a child and teenager growing up that's made to be such an important event in your life, becoming pregnant and having a baby, all the fairy tales and all of that. "Oh, it's going to be such a marvelous thing!" And then when [it] happened and I wasn't ready for it, it was just such a loss. . . . It was that "Wow! Here's this moment that society's told me is supposed to be so wonderful, and it isn't for me at this time." So having to sort of say good-bye to that myth.

Similarly, Yolanda harmonized her conflicting inner voices by distinguishing the inner voices from the outer ones. Therefore, she observed her body for signs and symptoms of pregnancy. Lacking such evidence, her guilt and ambivalence dissipated:

> Logically I knew it was the thing I had to do, but emotionally I think the nurturing— . . . It's hard to know you really do have a child in you. There's no kicking; there's no movement; they tell you you are pregnant. You are [pregnant] maybe. I don't even think I was putting on any weight at that point in time, so it's difficult to relate to, but yet you know you're going in and you're doing something that is maybe wrong religiously, that the Bible would not promote.

Conversely to Yolanda and Ashley, Olivia considered her pregnancy meaningful: "For me that was a child," she asserted. In her deeper self, Olivia desired to have that child; however she felt that she could not bring another child into the world at that particular time. She considered her decision to abort as "a sacrifice" necessitated by the other responsibility that she already owed to her existing child. Yet Olivia became deeply uncertain about the moral and spiritual implications of the abortion. As she stated below, her "emotional level" called that sacrifice into question just prior to beginning the abortion process:

> The day before, either I had been given or had to go get a prescription for some antibiotic, I think, that was to be taken before. And that somehow was this touchstone that . . . as soon as I took this, that was it. I just said, "You know, I don't know if I can do this."

Although speaking in more impersonal and abstract terms, Olivia initially attempted to settle the emotional voice with the rational in two ways. This included letting in the fetus, acknowledging that this was "life"; and, secondly, acknowledging her power to end that life. This acknowledgment might raise a question whether or not "deny[ing] a [potential] life" expresses wrongdoing: "I don't have a sense of this being right or wrong. Rather, I know that it's wrong to take a life." Acceptance of death surrounding this experience could help women dissolve their guilt over exercising such power: "I think that [abortion] was the most personal closeness to death [that] I had had up to that point" (Olivia). By developing comfort with this, Olivia was willing to assume responsibility for abortion:

> I need to hold on . . . to that image of death that I had. . . . I'd never had that before, and therefore there must be something right through all this wrongness. So I took the pill, at which point I just went, "Oh, God!" and I started to panic, like I had done a fatal deed or started the sequence of events, and I think we ended up calling the poison center or something to find out what kind of damage could be done to a child taking this antibiotic. They said something about blackened teeth or something in the worst situation, and then I went, "No, this is it. We're done here." Yeah, so I think, yeah, it was like I passed through that place of decision and . . . it's fine.

By accepting the responsibility for her abortion, Olivia was able to alleviate the moral struggle. Therefore, she rejoiced at establishing a bond with and demonstrating affection to that "child" prior to relinquishing it:

> It was at that point that I actually was able to spend time with this child, which made me deeply sad because I hadn't been able to do that before, I guess probably because I felt so guilty; and at the same time I felt really grateful to have finally come to that place of just having that even [if] it was just going to be for a short period of time. So . . . I think I was probably up most of the night, but . . . [I] felt a lot of relief at that point and, yeah, just stayed with this child, I guess.

Ashley, Reka, and Sinead also viewed ambivalence as a women's natural response to acting out difficult choices: "That's okay to be indifferent. If it's black or white, then there's something wrong" (Ashley); "To endure the antagonistic voices, it's like a willing sacrifice of the clarity for a while" (Reka); "To accept the gray area" (Ashley). As explained previously, the women formed their own moral agency lending grounds for making their choice. That moral agency was grounded in the context of their experiences associated with the unexpected pregnancy. Emotional survival and betterment of a woman's life, including the lives of her existing children, constituted the driving force behind the decision and the final measure of their responsibility. For example, Olivia stated, "It was only having the experience of a single mother that I could go 'It ain't easy' and needed to think about my other child here and what kind of life that will mean."

While controlling their emotions, the women predominantly employed cognitive reasoning in making their choice. However, the prospect of an abortion could discredit the "intellectual level" of thinking that was engaged in the decision-making process. As a result, the "emotional level" that "took over" provoked reflection on the moral/emotional implications of the abortion. Although different in nature, both voices reflect the ultimate concern for the betterment of the women's lives and quality of life of the newborn and that of their existing children. In spite of sounding like a nuisance, the emotional voice is viewed as integral to the process of establishing readiness for acting out the decision. Reflections provoked by emotions, however painful, engaged the women in conscious self-scrutiny, resulting in deeper insights about their own internalized cultural and religious values.

The women recognized that conflict between experiential knowledge and internalized values caused their guilt. For example, Yolanda stated, "I felt just guilty because you are struggling with your own morality and values." Reka commented similarly: "Your upbringing [might cause] a lot of ambivalent feelings." Armed with these insights, the women developed a greater sense of being responsible, even though they chose to nurture other priorities rather than those related to potential motherhood. Once the women assumed the responsibility for acting out the decision, they established readiness for acting upon their choice.

Enduring the Inevitable

Several of the participants were hesitant to act out their decision to abort regardless of the strong belief that this decision was the most responsible option. Other issues that many of the participants had to deal with on the abortion day included lack of privacy, fear of external judgments, and insensitive or abusive treatment from health professionals. Those challenges, in combination with the uncertainty of the implications of the abortion, caused one of the most intense moments of the abortion experience. To alleviate emotional discomfort and to maintain self-control during the procedure, the women employed two strategies, which are presented under two subheadings: (a) drawing a self-comforting fantasy, and (b) being on guard.

Drawing a Self-Comforting Fantasy

For Yolanda, "it was very, very difficult to go to hospital" to terminate her pregnancy. In addition, "lying there waiting" for the procedure could also be "a very emotionally, very mentally damaging time" (Amanda). At this juncture some women vacillated about acting upon their option, regardless of how reasonable their decision was. For example, while awaiting the procedure, Yolanda was "still questioning, Is this the right thing to do?" Similarly, Amanda, who believed that she "was a hundred percent ready for it," contended:

> Because you are not sure, you know there's that second just before you go into surgery that this is wrong, I shouldn't do this; but you know in the back of your mind that this is something you have to do because it's the choice for you, but you have to be sure.

Abortion pits the desire of bettering and protecting the Self against the woman's implicit moral responsibility to exercise care and to protect others from being hurt. As well, her pregnant body might instinctually bring up thoughts about motherhood. Yet, while facing the inevitable abortion, a woman is confronted with the paradoxical knowledge of her power to deny a life. Besides appeasing that awareness by accepting the current values or reconstructing or redefining values in the context of their experiences, some women had to cope with their maternal instinct and impending losses associated with that experience. For example, Ashley consoled herself by imagining the fetus' departure and saying a loving farewell:

> Another way I guess that I coped was that I sort of said . . . good-bye to that little spirit, and I said, "I'll see you later. I'll see you in another time. . . .You just go away right now, little spirit, because I can't be your mom and I can't go through with this, but you will come back to me."

Without previous experience of maternity, Ashley exercised a maternal decision by denying the life she could not nurture at that particular time. The notion that the abortion reflects a maternal responsibility and that saying farewell to the fetus could be considered as coping with its departure was supported by Nancy Huston (1997): "I'm your mama, you should trust me, I know what's best" (p. 244). By holding onto the image of a loving bond with the fetus, Olivia was enabled to let its "spirit" go in full and affectionate consciousness: "Then we went in the next morning, and . . . I remember very clearly this image of me just holding this child, and that's all I held onto, was that." Correspondingly, Olivia imagined a departure of "the child" with comfort and love. In her fantasy, Olivia comforted herself by ensuring that the relinquished "child" would be protected and cared for with respect. Olivia's comments provide a clearer picture of a comforting fantasy being used in coping with the inevitable separation from the fetus:

> I remember lying on this bed. It was between where I was and waiting to go in. . . . I had again the image of the woman coming with the basket to take the child, and at that point I knew that . . . this child would be taken care of. . . . I didn't cry. . . . I felt . . . comfortable knowing that there was . . . something, somebody [who] had come [with] a lovely basket that had been prepared for that child, . . . so the child would not be left on [its] own.

By contrast, Reka still felt unsettled about exercising her decision, even though she understood that her choice to abort was the best alternative. Despite the profound need for emotional support which she experienced at the time of the abortion procedure, "painfully distant" health professionals created a "very cold" and "impersonal" atmosphere. That atmosphere compounded the distress already arising from Reka's impending loss. On the edge of her survival, she fantasized that her husband would protest the abortion. Then she decided on a trade off to achieve psychological balance, which, in turn, allowed the abortion process to continue:

> I remember spending the time just wanting to stop the process, feeling numbed and in a process of wanting to stop it but not being able to. Waiting, hoping that my husband would say he changed his mind. . . . So anyway, one of the conditions or the condition of the abortion was that I also have my tubes tied, which was not a big issue for me because I certainly didn't want to revisit this situation again.

Two participants found comfort in distancing themselves from the experience. Dissatisfaction with the care being provided to these women during the abortion procedure might have added to the need to distance themselves from the experience. Although not explicitly stated, that explanation of distancing could apply to Olivia. She reported:

> So then, yeah, we went through all the rigmarole of just kind of all— . . . there was a bunch of women in a room, mostly young—and one by one started going through this ritual of [preparation for the abortion procedure]. I can't even remember getting changed and the IV. Then to find a bed and then we were brought in. So all I had taken from it was that image just before I went in and the glaring lights.

Alternatively, Barbara definitely distanced herself from the experience to help herself cope with the sexual assault during the procedure. Her citations offer a clearer picture of her experience of coping with the procedure:

> [The abortionist who] actually was very crass and kind of treated [it] like it meant very little to me to have the abortion, and then was sexually provocative and said that he had to do this certain kind of thing which imitated the sexual act. He did it with his hand as he repeatedly rammed his hand in and out of my vagina, . . . and when I reacted he said, "This is what we do to make the uterus contract." And so I took it like an absolute—like it was the thing that I had to do. And I took it too as a form of punishment. I was thinking that he was angry at me or whatever.
>
> I think I must have done a certain amount of kind of zoning out and going somewhere else. I must have disassociated a certain amount of it. I just remember at the time it was like being in a dentist's office.

On the other hand, Yolanda maintained symbolic awareness of the impending losses associated with the abortion while waiting for the procedure:

> [That] time I'd be aware of it. I suspect that why I associate clocks to that is that when you're lying in the waiting room to go into the operating room there're clocks around, there [are] different things. That's what you focus on, the clocks. You're aware, "Well, I've been lying here an hour. When are they going to take me in?" That's probably why the clock is a symbol for me.

For Ashley, coming into the clinic at "five-thirty in the morning" accounted for the most difficult aspect of the experience. Furthermore, sitting in the room with 11 women and "staring at each other, . . . know[ing] why we are all here, . . . it was just so humiliating" (Ashley). By allowing herself to be angry at health professionals, Ashley was able to endure the process of the abortion.

Being on Guard

The moment a woman approaches the medical community to obtain an abortion, her private life is subjected to public scrutiny. This situation, which can elicit fear of external judgments, can decrease their sense of self-control. The women participating in this study employed several strategies to maintain a sense of self-control to protect their vulnerable selves. For example, Sinead endured a self-induced abortion in silent shame without sharing it with anyone or giving any indication of bearing such an experience:

> Anyway, that's what I did, and somehow I got the catheter in after about three nights of trying; I went around with a Foley length catheter in my uterus. It's astonishing. I just carried on and went to work every day. It's amazing that I could think of all this stuff and what I needed to do. I feel real weepy when I think about it, the desperation of this poor young woman . . . who already felt like a branded woman.

Although Paula obtained her abortion from one of "the angel-makers" (Huston, 1997), who was an illegal abortionist, her abortion was still incomplete. Consequently, she developed life-threatening complications; yet she strove to maintain privacy by delaying reaching out for professional help. Going back 30 years, Paula recalled that particular experience as follows:

> Then the third day I went to work. God, I had started really bleeding, and so I had an excruciating pain and I thought I had to go the bathroom, and I passed the dead fetus. I couldn't make out a fetus; it just seemed like a great clot. Then I started bleeding and never stopped. I still didn't do anything. I wore a lot of pads and that until I got to a point where I had to go into the hospital and have a transfusion because my hemoglobin was way down. I could've had anything, but nobody at that time knew about it except the nurses and the doctor when I went in for the blood transfusion, and they were okay too.

Similarly, Bev, while enduring a self-induced abortion, maintained "a lot of privacy." She performed the abortion when she "was alone at home." Although surrounded by close family members, Bev did not want them to know that she was "really very uncomfortable" from the pain. Bev's straightforward explanation of how she coped is as follows:

> I really felt embarrassed and didn't let them know I was in real pain. You know, keep things to yourself, because it was my decision and I had to live with it. But I never thought that the pain would be like a punishment; I thought it is like, Gee this is happening. It's like when your period comes, only it's a little bit harder.

Likewise, Barbara and Paula, who endured illegal abortions, managed to maintain a sense of self-control by not exhibiting any discomfort from their pain. For example, Barbara stated, "[I] anticipat[ed] pain, and when I did feel it, I took it without [making] a sound." Similarly, Paula said: "I was terrified but, of course, not to show it." Christine employed a different self-protective strategy to ease emotions and feelings arising from the unpredictability surrounding the procedure. She anticipated that the procedure would be performed in an uncomfortable environment in which health-care providers would treat her unkindly: "I had imagined in my mind prior to going, the procedure was going to be horrible, going to be scary, and people weren't going to be nice to me. And I actually found just the opposite." Fear of pain and embarrassment was also expressed by two other women who allowed the researcher to observe them during their abortions, but declined participation in this study. One woman warned the assisting nurse that she "might use bad language . . . or punch the doctor" during the procedure. Her open communication of feelings resulted in more compassionate care. After exploring appropriate ways of expressing distress, the nurse held her hand and gave her a hug to alleviate discomfort from the procedure. Another woman received additional reassurance from her escort. When experiencing pain, she squeezed her friend's hand to maintain self-control.

Shortly after the procedure, Cassandra cried and wondered about the reason behind her crying: "I've seen the fetus' heart on the [monitor] screen. That's probably what made me cry, . . . and the drug I was given before the operation." Similarly, Yolanda could not contain her emotions, which were provoked by her body's reaction to the anesthetic and the nurse's use of the phrase "It's over." Paradoxically, Yolanda regained some self-control by understanding the triggers of such emotions:

> It was a traumatic experience when it happened. I remember waking up in recovery and the nurse just basically saying to [me], "It's over," meaning that [the] operation was over, but I somehow interpreted it to mean "It's done, you did it, you got rid of it," and I cried and cried and cried and cried, and they had to knock me out in the recovery room because I became very . . . emotional. It's really the only time I became out of control, and a lot of it probably would have been due to the anesthetic having that affect.

Moving On

Once the procedure is over, the crisis of unplanned pregnancy is resolved. After resolving the crisis of unplanned pregnancy, the women normalized and moved forward with their lives, although for many the process of surviving continued. Fearing social stigmatization and trying to live up to the image of a "good woman," these participants concealed their experiences. For this reason they were unable to deal with the implications of their abortion unless they were surrounded by a circle of supportive family members or friends. The variety of coping strategies that the women used are discussed in three sections: (a) continuing on the path, (b) shrouded in secrecy, and (c) grieving in darkness.

Continuing on the Path

Following the abortion procedure, the women usually "continued on the path." They assumed their prior commitments, trying to normalize their circumstances and move forward with their lives. For example, Bev "started to work" after staying home for two days. Similarly, after taking "the day off work," Olivia resumed working the next day. Likewise, after her second abortion, Sinead who had

> had a general anesthetic in the morning, came home and prepared an evening meal. . . . I just wanted to get on [with] my life, and pay no attention [to my experience]. It's like having a haircut. I paid more attention to dental work. That had a lot to do with shame.

Yolanda reviewed her future goals and commitments; then she followed her plan to achieve her personal growing desires. To make that statement more objective, Yolanda declared:

> After [the abortion procedure] was done and you came home and you became emotionally stronger again, you go on, and I think it gave me, like I said before, it probably gave me momentum to reach my goals because I had given up something, so that I could continue on the path I was going and make sure that I implemented it.

Similarly, Paula continued on the path "by going back to work," "going back to school," and "absorbing" the experience. Barbara and Christine employed other ways of coping by moving from surviving to healing:

> So I got into a lot of physical labor. That way I was creating. I wasn't creating a child, but I was creating and bringing a dream that I had about building and improving. So I got back to my roots in the prairies, which was very nice. (Barbara)

> [I] started working and just really securing our finances, fixing up our house and really getting to know each other in cohabiting. That was enough; that was enough to keep us busy on a daily basis. (Christine)

For Christine it was "living in the moment" and "pulling out the joys of each day." For Caroline, it was looking into the future:

> Try to nurture my own relationship and my life and nurture myself is what I try to do. If I find myself ever getting too far into the future or a little bit too far into the past, I stop and say, "What about today? Am I enjoying today?" (Christine)

> [Abortion] is a fact of life and you move on. I see no point in sitting and dwelling on the past. Change it. But you can't change the future if you don't change your outlook and your attitude. (Caroline)

To move forward with their lives, the participants reevaluated the relationship with their partners. Olivia and Bev decided to get married. Reka continued with her marriage. Although Yolanda ended the intimate relationship with her partner, she maintained a long-lasting friendship with him in spite of "the feeling of rejection from [him]." Barbara "ended up splitting up" with her boyfriend even though he "asked me to marry him." Similarly, Amanda concluded the intimate relationship despite the partner's effort to resurrect that relationship: "[Two] days after the abortion he came and said, 'We have made a mistake,'" but Amanda replied: "It was not a mistake."

For Ashley, ending the relationship with her partner "was a very struggling moment." "I needed to evaluate why I couldn't stay in the relationship." For Caroline, "the callous[ness] of the boyfriend" accounted for "the most difficult" aspect of the abortion experience: "He didn't want me to go through with this pregnancy, and I was flabbergasted because we had been contemplating getting married. It really threw me. . . . I just thought, 'You are out of [my] life. Good-bye.'"

Sinead also ended the relationship: "He was John Wayne's clone, I'll tell you." As a result of deeper insights into the value of taking the responsibility for caring for oneself, Paula also concluded the relationship with her partner: "I was very, very foolish and immature, expecting the man would also be as responsible as I was."

Shrouded In Secrecy

Given the social stigma associated with abortion, paired with the lack of adequate social support, the women utilized another strategy to protect themselves from the negative influence of others. In this study the strategy of shrouding the abortion in secrecy included two mechanisms. The first pertained to putting on a façade and pretending to be intact, while the second consisted of remaining silent about the whole experience. Depending on the surrounding social environment and the attitudes toward abortion, combined with the personal strengths of the women, the participants used one or both of these strategies. For example, Barbara, who was deeply affected by the abortion and the associated experiences, "had to confront the world that everything is copacetic, like it's all the same as it was, when my universe in fact got turned upside down." Therefore, feeling "fragile," she employed these two avenues simultaneously; however, neither of them appeared to be effective in resisting social judgment.

For example, Barbara "came back to work completely vulnerable." While she was getting a cup of coffee in the cafeteria, "this big guy" with whom she worked said, "Where did you go for two weeks, to get an abortion?" Although Barbara put on a façade and remained silent about her experience, she felt transparent and permeable:

> I was so flabbergasted. I thought for a minute that somebody told him. No one knew, but the shock in my face would have told him that I did, because it just about put me on the floor, you know. So that was a strange situation of all things, but it just shows you too that your vibes or whatever is going on in your head is just out there in the world. Whatever would have made him say that? Very scary.

Even though Barbara employed both mechanisms to protect herself from social judgment, she experienced difficulty with separating herself from the harsh world. Consequently, she felt: "found out and stupid for falling into some social trap that had nothing to do with anything, but yet had everything to do with me." Similarly, being "embarrassed . . . and suspicious about other people" judging that she had "done something wrong," Bev "wanted to stay away from everybody," although she found such a situation to be "impossible." Sinead "couldn't let anyone know that [she] was this absurd," so she pretended that nothing had happened, that she "had a haircut or something."

Although Paula shared her abortion experience with close friends, she nevertheless refused to concede the emotions arising from this experience:

> I cried and cried, and then of course when people said, "Did you cry some more?" I said "No." I said, "I was too busy taking care of my friend," so I kind of turned it into a joke. The other [abortion] I didn't cry but I felt, I truly felt then that I had lost a child.
>
> Maybe I felt if I had it done and I'm so happy or glad that I'm not pregnant anymore. Maybe I thought you had to stay happy. Maybe that was it. There was just a part of it that way.

By contrast, although Barbara reached out to her friend for support, she "couldn't really seek counsel from her." Moreover, Barbara "didn't feel free to talk about [the experience] with her [girlfriend], . . . [so she] just pretended that [she] didn't need to talk about it at all." Keeping the abortion experience a secret can be a strain, but considering the experiential data obtained in this study, the women suggested convincing reasons for shrouding their experience in secrecy. For example, Reka stated: "It's just an immense fear and terror, and a lot of it is reflective of social ideas." Correspondingly, Amanda said: "Women are shunned and frowned upon if they have an abortion in this country, which is wrong, because it is a woman's choice." Bev elaborated on the motivation for the secrecy surrounding abortions:

> I think most of them will feel uncomfortable to talk about abortion because of the bias that there is. Women in most of the cultures, you know, are the main caregivers, the nurturers, the mothers. So this is like undermining their role because they have an abortion maybe. . . . They want to further their careers, so they are kind of more like men. I think people reject that, you know.

Olivia, who experienced "a lot of judgment" during the abortion procedure, "hadn't told anybody about" the experience besides her husband until several years later. Similarly, Sinead, being "really embarrassed about" the self-induced abortion particularly, "never discussed it with a girlfriend or anybody at that time." Identically, Barbara remained silent about the sexual assault by the abortionist for many years: "I never really ever told either one of them [physicians] what happened or how it happened. It's probably, you're the only person I've told about that."

Other women remained more "selective" rather than "secretive" about divulging the experience. For example, Bev avoided "hurting her [family members'] feelings" by "hid[ing]" the experience from them; however, she felt "ashamed" that she had to go through the experience "hiding" it. Similarly, Reka did not share her experience with her mother, who "was fairly fanatically anti-abortion," because she feared her disapproval. Moreover, Reka was petrified about revealing her experience to others for fear of being judged; yet she would share her secret with someone exhibiting a supportive attitude:

> There were quite a few years where it wasn't a terribly open topic, but over the years, since I got older, the women I know, I would share my experience. Then I would find that other people, once they knew it was safe, were happy to share their experience.

Longing to untangle the burden of grief and sorrow, Reka "had unfortunately confided in" a presumably "kindred spirit." Rather than being nurtured and comforted, a close family member inflicted shame and guilt upon her by accusing her of being a detriment to society and family:

> When I went to [my sister-in-law] she indicated that . . . society around us considered me wholly responsible and that I had done a bad thing, and my husband's entire family shunned me for a period of time. … . [My] husband's family [thought] I was evil, just totally evil. I mean, it got to the point where my mother-in-law suggested that maybe my children shouldn't be with me any more.

Dreading judgment and discomfort, Yolanda and Sinead experienced the anxiety of disclosing their abortion to health professionals. They felt compelled to reveal such information to health professionals when obtaining health-care services. Feeling that "discomfort," "embarrassment," and "shame" while being asked repeatedly about her obstetric history, a woman might attempt to parry the awkward questions. For example, by using more socially acceptable terminology such as "dilation and curettage," Yolanda dodged the question about having had an abortion:

> I found that difficult that day. I wanted to say D and C, but they wouldn't let me get away with it. I had to be more specific and describe why I was there. It brought me to tears almost every time. That practice still follows, that when you go in to—and again being interviewed five or six times: "How many pregnancies have you had? Did they go to full term? Were they miscarriages, or were they self-directed?" . . . Earlier I said I don't feel ashamed to talk about it, but I do recall now feeling uncomfortable. Maybe it's after the fifth time [of answering the same question]: "Why didn't [you] carry it to full term?"

Similarly, Sinead disclosed only partial truths while questioning her physician's motives:

> I was in the doctor's office the other day and she says, "How many pregnancies have you had?" I never even thought; I just said "Two." Then I said to myself, This might be significant so I said "Four" for the first time. How many times have I been asked how many pregnancies have I had, and I have never admitted it to one single doctor. So it does affect us, all of that guilt and all of that stuff. And I still have secrets and lies that I would not tell a doctor. . . . I didn't tell her I had an abortion; I just told her I had four pregnancies.

Considering that abortion is downplayed socially, the majority of women shrouded their experience in self-imposed silence to protect themselves from shame and social condemnation. Depending on their support network, a majority of the women kept their experience secret for varying periods of time—from several weeks to many years. After Reka shared her experience with her family, she was shunned. Consequently, she remained silent about her experience for several years: "We weren't allowed to talk about [the experience]. Even if you had been willing to be open [about it], there were not receivers. That certainly was my experience." Keeping the abortion secret was ineffective for Amanda: "I live in such a small little town, there are so many people that know me, and [when they] found out that I had [an abortion], it . . . caused a little bit of mental anguish."

As the experiential data in this study indicate, society often perceives abortion as a plight, shaming and embarrassing the women who have had such an experience. Therefore, based on the knowledge derived from the women's particular experiences, shrouding the experience in secrecy can be considered a healthy, self-protective mechanism to avoid social stigmatization. Paradoxically, this self-protective strategy of keeping the secret might also shame a woman. Consequently, a woman might carry two burdens rather than one. For example, Bev felt "ashamed of hiding the experience from [her] family." Reka stated, "It's an agreement that you have something to be ashamed of if you're keeping secrets." The consequences of keeping the secret were further explained by Amanda as follows: "That's mentally anguishing [keeping a secret], because that will come up and haunt you in years to come, in future relationships; it will definitely come back up and creep up on you."

As a result, the paradox of keeping abortion a secret became extremely complicated and difficult to untangle. First and foremost, the women decided to keep the abortion secret to live up to the image of being "a good woman," thus protecting their self-esteem. In the background however, those women endured more shame springing from the secret. Additionally, the women were shamed into secrecy by society's hostile attitude towards abortion. This prevented further resolution of such an experience.

Furthermore, the resolution of the abortion experience requires dealing with the losses associated with such experience. These losses need to be addressed and acknowledged by another compassionate human being in order to be successfully resolved. Given the prevailing antagonism towards abortion, oftentimes the women could not grieve openly about their losses. To facilitate moving on with their lives, the women employed another coping strategy that will be elucidated in the following section.

Grieving In Darkness

The metaphor "grieving in the darkness" was used to describe the process of separating from the painful aspects of the abortion experience. In this study all the participants experienced "a loss" associated with their abortions. Four of the participants began grieving before the abortion, and two of them continued with this process after. Several others initiated their grieving processes either immediately following the abortion or weeks, months, or years later, unaware of their unresolved grief in the meantime. Despite holding their unresolved feelings at bay, the participants grieved over the losses without conscious awareness:

> [I] couldn't communicate or motivate my [partner] into recognizing my feelings . . . about [taking away] the life of this child [and] my feelings about [losing] it. . . . There were a lot of years, a lot of time when [I] would sink [the experience] below consciousness, [so it] wasn't really a part [of my life]. (Reka)

When kept underground, the unresolved feelings can become detrimental to health. As exemplified by 4 of the 12 participants, their unresolved grieving was channeled into dormant forms of "depression," "haunting dreams," and unhealthy habits: "[Although the abortions] w[ere] the best [alternatives to my unexpected pregnancies], they affected my whole life, [because] I went through [each experience] in such an unhealthy way [without realizing it]" (Sinead).

Based on the context of this study, there are four major categories of losses associated with the abortion experience: the change-related losses, such as "the loss of innocence"; the loss of relationship; the loss of a potential child; and the loss of potential motherhood. For example, Yolanda acknowledged: "There was a loss of our relationship, [knowing that the relationship] would [not] survive. We only survived a year or two after [the abortion]." Catherine accepted the abortion as the "loss of the Being that was part of

[her]." A parallel sense of loss was expressed by Amanda: [I] lost a part of m[yself]. It was really part of me that was going to grow and become [an independent part of me]." For Sinead, the abortion produced a feeling of loss, which she defined as "incompletion of a natural process, . . . something that was going on in my body [and] was not allowed to come to completion."

Similarly, Caroline identified her abortion as "a loss for yourself for what [you] would've been. I think it's a grieving, even though you've made the choice: This is what is right. You go through a grieving process." As a result of different social support systems, the emotional strengths of the participants, and the individual experiences associated with their abortions, the participants chose different ways to cope with their losses. These are presented in the next section.

Running away from sadness. Running away from sadness was a coping maneuver employed by several participants. Considering the lack of collective recognition of abortion as a loss, these participants negated either the entire abortion experience or certain aspects of it to elude painful emotions. For example, to escape from intense emotions and therefore to "go on" with life, Sinead had "never dealt with" the experience until her retirement. To avoid confrontation with guilt, she had "never even given it a conscious moment." She had never explored the moral implications of her abortion: "There was no question if it was right or . . . wrong. If it was wrong, I'd done it and I'm alive and my kids are alive and that's it." Nevertheless, Sinead's disturbed psyche, while seemingly imperturbable, manifested emotional pain and unresolved grief in "a haunting" dream:

> I had always, always had a dream about a child in a green sweater that I had forgotten to look after. Come to think of it, I don't have that dream any more. It was a haunting kind of a dream, a little kid in this green sweater.

Sinead also recalled having "incredible fantasies for years" about becoming pregnant and having a baby. However, she consciously dealt with those fantasies in the following manner: "A man came into my life, as soon as I . . . looked at him, I knew that I would be pregnant with him, and I would be so happy to be pregnant. I tell you, I raced and had my tubes tied." Similarly, Reka "would frequently imagine through some magic [that she] would be able to have another child," although she had already taken other measures (tubal ligation) to prevent pregnancies. Her grief-induced fantasies manifested themselves in dreams: "I would have dreams about this person who had in my mind the name of Ira, and was a boy child" (Reka). Unlike Sinead, Reka paid attention to her dreams and felt the loss. Being pressured by other commitments such as moving to a new house, Reka did not successfully resolve the grieving process until some years later. In the meantime, she often ruminated about that loss:

> [I] got it in my head, believed that this child was a boy—like I knew, like he was a person. It was a person and he had a name and I could visualize it. Yeah, my thoughts about it were really obsessive. I cried a lot; I cried uncontrollably.

Barbara, who experienced the "pain of losing the pregnancy," framed "a mental block" to separate the experience from her life. She was as traumatized by moral conflict as by the sexual assault during the abortion procedure and the lack of subsequent support. Barbara explained: "I was running away from sadness" as a way to ease the emotional pain. As result, "instead of sitting quietly, contemplating and integrating and feeling [the experience]," Barbara had "mov[ed] too fast, almost negating the whole thing" for over 20 years. By running away from sadness with a great expenditure, she consequently developed unhealthy habits such as drinking and smoking cigarettes and marijuana. Nevertheless, her emotional pain, although held at bay, did not evaporate; instead, it resurfaced in another dormant form—"depression." Paula also acknowledged that she buried her experience: "I didn't deny [it]; I placed it somewhere else. . . . It still comes through, . . . but I'm pretty introspective."

Feeling the loss. By contrast, some of the participants had already associated the abortion with loss and began to grieve over it the day preceding the abortion procedure. For example, Ashley and Catherine held a dialogue with the fetus to end the relationship in an honorable and peaceful way: "You just go away right now, little spirit, because I can't be your mom, and I can't go through with this, but you will come back to me" (Ashley). Catherine "gave a recognition and farewell to [the Being] with a candle. . . . [She made] a very conscious effort to communicate to the Being . . . a conscious farewell." After crying for a lengthy period of the night, Olivia created the image of a loving bond with the fetus:

"I remember very clearly this image of me just holding this child, and that's all I held onto." Despite the unresolved feelings, she "shut the whole experience out . . . the next day" following the abortion.

While expecting the loss of relationship, Yolanda "cried and cried and cried" the night before the abortion. However, she had been avoiding confrontation with the moral aspect of the abortion for several years following the abortion procedure:

> Is this child a human being or is it not? I am killing a human being, or am I not? I avoided that completely at the time, so then had to deal with it later in life and go through some feelings on that.

Yolanda continued to mourn her loss of the relationship with her partner and the loss of potential motherhood that she had felt the night before her abortion. Twenty years later she still reflected on that time:

> [I] did come home and rested in for a couple days and felt a sense of loss. For at least a month every week at such and such time, I would be in class, look up at the clock, and start to cry. I still reflect on that time.

Similarly, Amanda recognized and experienced loss related to her abortion following the procedure. Several months later she stated:

> Shortly after the procedure I cried a bit on the way home. You know, there's still that touch of loss, but it's not a sense of loss to the point where I couldn't handle it. And I knew it wasn't a baby; it was a fetus, something that had the potential to be a baby. I'm still dealing with it. Once in a while when I see a baby it will hurt. It still stings, but it's not to the point where I can't go on with my life and I can't handle it.

In similar situations, the participants often recalled their reasons for the abortion to try to establish a sense of accountability for the decision: "I guess just reviewing over and over in my mind why it is that I had to make that decision" (Yolanda). Although the above strategies allowed the women to move forward with their lives, they still remained in the surviving stage. To facilitate the transition from the surviving to the healing stage, the women had to validate their losses and express their feelings and emotions. Taking into consideration the content of the interviews, Amanda's explanation captures the significance of effective coping with the implications of the abortion. Successful coping with the experiences associated with the abortion is crucial for maintaining control over the quality of life:

> You're going to deal with the consequences, and you have to be able to deal with them, because if you don't, it will ruin your life. It will haunt you like before. It will haunt you if you are not a hundred percent sure. It will haunt you until the day you die, but you need support.

As considered by the participants, social support is essential for optimizing the healing process. A lack of social support might constrain women's potential for achieving a reasonably brief healing time: "Usually [women] that have had abortions and have no support are the ones that it takes them a little longer. They don't let it go as quickly. They bury it" (Paula).

Stage Two: Beginning the Process of Healing: The "Power of Love"

Making a "life-and-death decision" was how two of the participants viewed their abortion. It is a rational process that often finds its source in love. Love for the Self, for the Other, and for existing children became a powerful tool that guided the women into making a thoughtful choice. This power of love reaches beyond the acceptance or rejection of a potential life and values life beyond the norms that are established by the patriarchy or by abstract moral principles. It already assumes a life but places it outside of an idealistic conception into a reality that is different for each woman. For the women in this study, this reality raised concerns about the dignity and quality of life "not just for [themselves]," but also for the lives of others, including the newborn. This concern was mirrored in the questions that the women frequently asked themselves while contemplating their choice: "[Am I] prepared emotionally and financially to care for this child?" (Catherine); "What could I offer this child?" (Amanda); "[How would caring for this child] affect my [existing] children?" (Reka); and [What are] my goals to make myself complete?" (Yolanda)

Such thoughtfulness is an expression of responsibility and strength. Denying the potential life was "best for [the woman] and for that child at the time" (Amanda). The courage to choose that act suggests incredible strength. The source of "power to give life" is also the source of "power [to deny a potential] life." On this continuum, the power to deny a potential life is generated by the power of love that had already been developed from maternal instinct and was found in the rational decision: "It [would be] very selfish of me to keep the child" (Sinead). For the participants, the abortion decision, which was acted out of love, resulted in both losses and gains. For many of them, the abortion was a painful experience. To achieve resolution of the abortion experience, the participants entered another stage—the healing process. Catherine, who dealt differently with each of her abortions, commented: "Healing depends on what kind of a wound you have in the first place. There are ragged wounds, and there are very simple punctures. There are wounds that get infected very badly, but there are also clean cuts."

The abortion itself might produce a "clean cut" even if it involves losses, but exposure to a hostile social environment might cause infection, extensive scarring, or delayed healing. Depending on the emotional wounds sustained from the experiences associated with their abortions, the participants used various mechanisms to promote healing. Once the participants entered this stage, they gained awareness of the unresolved experiences, acknowledged and validated their losses, and began healing their emotional wounds. They often recognized the wounds that had not been healed when they were challenged by other significant issues or other difficult choices.

By validating their losses and by confronting social injustice, the participants accomplished healing. This stage comprised three phases (Figure 3): (a) recovering the unresolved experiences, (b) putting the "little ghost" to rest—validating the abortion as a loss, and (c) shining the light: breaking away from the shadows—the empowering phase.

Recovering the Unresolved Experiences

Recovering the unresolved experiences, thus allowing the Self "to go through . . . sadness," was another step leading towards healing and closure of the abortion experience. Based on the knowledge derived from the women's experiences, going through sadness was a necessary measure leading to self-renewal and personal growth. Therefore, resolution of the abortion experience appeared unequivocally to be a growing process. Considering the patterns evolving from this study, such resolution exhibited a cyclical pattern. This notion was expressed by Catherine: "Healing doesn't necessarily just last three months; . . . it is an ongoing [process]." Sinead elaborated on this process:

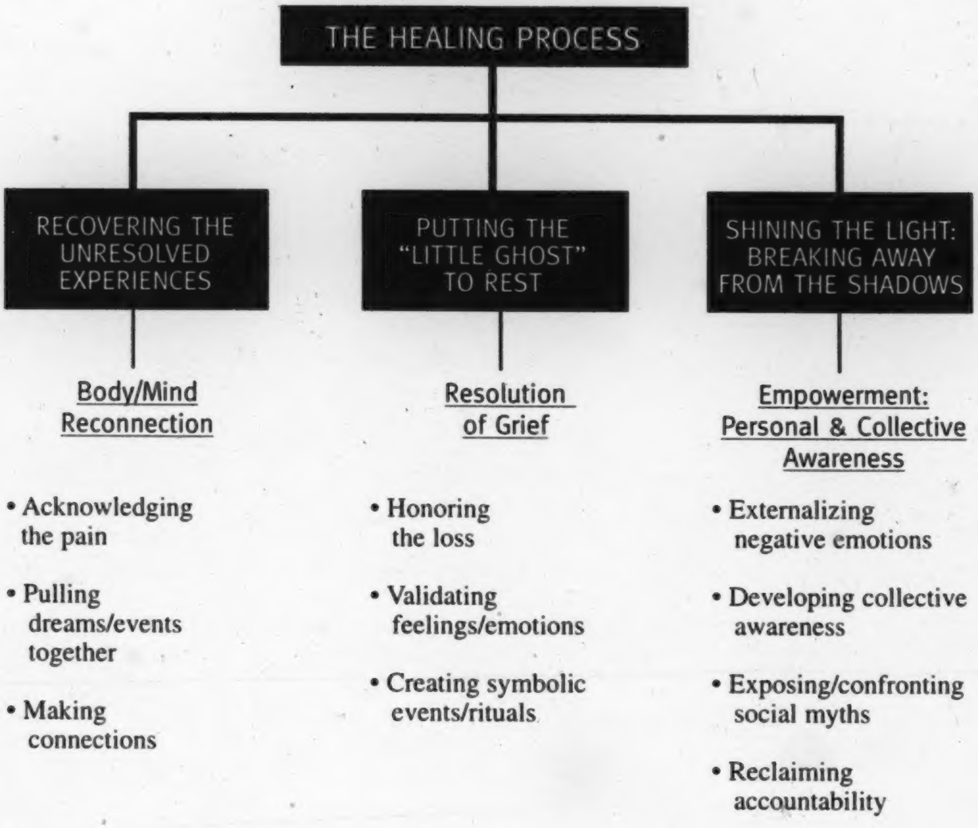

THE HEALING PROCESS
RECOVERING THE UNRESOLVED EXPERIENCES
PUTTING THE "LITTLE GHOST" TO REST
SHINING THE LIGHT: BREAKING AWAY FROM THE SHADOWS
Body/Mind Reconnection
• Acknowledging the pain
• Pulling dreams/events together
• Making connections
Resolution of Grief
• Honoring the loss
• Validating feelings/emotions
• Creating symbolic events/rituals
Empowerment: Personal & Collective Awareness
• Externalizing negative emotions
• Developing collective awareness
• Exposing/confronting social myths
• Reclaiming accountability

Figure 3. Stage Two: Beginning the healing process.

> [Healing, I] thought it was finished, and I was healed, and . . . then . . . [there] were other issues that came up in [my] life [many] years later that I had to deal with. Suddenly, [unresolved aspects of the abortion experience] came to me. (Sinead)

The women's acknowledgment and validation of their hidden experiences along with buried emotions and feelings were called on in different ways and at different times. When other significant life events occurred, the women's unresolved feelings and emotions resurfaced, assuming a new dimension and shaping a new meaning of the experience. "I suppose you are at different stages of it as you [go through the other] life experiences. . . . You then deal with it at a different level" (Yolanda). For example, "Having a baby would've been another growing stage" and "Loss of a child . . . probably would've been another step" (Yolanda). However, when Yolanda accidentally encountered information in the bookstore concerning fetal development, it triggered an unconscious moral issue regarding her abortion. The incident that occurred approximately four years after the abortion was explained by Yolanda as follows:

> It hit me there at that time, realizing what I had done to this fetus, because it said, you know, at one week this is happening, two weeks, three weeks; so many weeks it has its own personality. I remember the quote, "It has its own little fingers, face, and personality," and it was, I think, at probably twelve weeks, and I had the abortion at thirteen weeks, so I became very emotional in the bookstore, realizing then what I had done. Just the words, the way it was written, that's when you get into Pro Life.

The other events that triggered the connection with unresolved feelings and emotions surrounding abortion were recalled by other women. Sinead, for example, at the time of her retirement "started paying attention to dreams that I've had over the years." For the first time she "pulled dreams together" along with "paintings" reflecting the dreams and began to recover the meaning being conveyed through them. Other incidents, such as a "broken wrist," drew Sinead's attention to another "profound dream": "I was standing over my pregnant belly and looking down . . . and seeing this little being in there." Similarly, Barbara, while being deeply touched by her "[parent's] death," was intrigued to trace the origin of her emotional suffering. She explained the cathartic phenomenon as follows:

> So I think it happens when there is a big loss. It puts you in touch with your loss. So I think that's really what happened. He saw me at that time, this [psychic] person. He saw me as looking really fragile and exhausted, which I was because of my [parent's] death. . . . It really [put] me in touch with how much [pain] was in my life, the really painful [experiences] that I thought I knew about, but I really wasn't aware of them. . . . [I] probably wasted a lot of my life being apart from myself.

Encounters with symbolic associations around death could account for other cathartic events that released painful feelings associated with the abortion. That notion could explain Olivia's reconnection with her experience:

> Then I think it was about two weeks later I was walking, for reasons I don't recall, across the High Level Bridge, and about halfway across I just started sobbing, and I recognized where it was coming from and ended up running the rest of the way across and sort of collapsing. There's a little park there, and [I] just cried and cried, just kind of getting it all out, and it somehow had gotten lost in there after the experience or something.
>
> My body was mourning as well, and I didn't quite attend to it. . . . [I] hadn't given my body a chance to heal from the trauma. . . . [My body] was crying too. There was no child to hold; suddenly it was gone. So a few years later I had miscarriage, and . . . I did allow myself to go through that sadness in my body.

For Amanda, encounters with a baby occasionally triggered reflections about her loss. For example, she elaborated, "I'm still dealing with it [the loss]. Once in a while when I see a baby it will hurt; it still stings. But it's not to the point where I can't go on with my life and I can't handle it."

Putting the "Little Ghost" to Rest

Depending on the individual woman's creativity, talent, and resourcefulness, the study women employed various strategies (Figure 3) to bring about closure to the grieving process. This closure was accomplished by validating the losses as well as the emotions associated with the abortion. Validation of the loss through rituals was important for three participants. However, there are no socially recognized rituals associated with abortion to validate the loss by openly sharing sadness with others. Consequently, allowing oneself to openly grieve the losses requires great courage. In addition, there is no real legitimized symbolic representation of the loss; therefore, grieving requires creativity. In this study the participants employed burial rituals, ritual storytelling, ritual gatherings, visiting a cemetery, or holding a dialogue with the fetus.

Although the burial ritual was performed by only two participants, the importance of such a ceremony was indicated by the women participating in the focus-group discussion. For example, Sinead referred to Claire Culhane as "an amazing woman in Canadian history" who requested "to take the fetus home" and buried it afterwards. Also, Ashley mentioned an "aboriginal woman" who brought the aborted fetus home and "buried it" subsequently. To grieve successfully and thereby move forward through the healing process, Catherine and Olivia created symbolic representations of their losses by using objects meaningful to them. Subsequently, they buried the symbolic objects representing their losses:

> I remember at one point I had just some mementos of the particular relationship that I was in with the father of this situation, and a number of things that just meant something to me from that actual time. And later, much later, they were all together, and I actually buried them. That was one thing; that was a symbolic sort of thing. I buried it. (Catherine)
>
> I ended up putting in the vase a frog ring that I'd had for many years—I loved it very much— . . . and some dried flowers, thinking of this child, . . . and I sealed the top with bee's wax. (Olivia)

She buried the vase in the backyard. For her partner, this ceremony initially did not make sense: "He thought [that] I was crazy. He just thought I had lost my marbles." However, when he was emotionally involved in this ceremony, he gained a better insight into Olivia's expression of grieving: "I asked him to read a passage from T. S. Eliot. . . . When he read it, he started to cry and he recognized . . . what all this was about." For Olivia, her partner's validation of the loss was important to put her grieving experience into perspective. Her partner could validate her loss by releasing and understanding his own feelings. Reading passages from poetry can release deep, complicated feelings. For example, Sinead stated: "Drama, art, and poetry trigger the emotional response needed for the review of old emotions, leading then to healing. . . . [There is a] better chance of healing when a story evokes emotions."

Storytelling accounted for another ritual strategy used by several participants to honor the losses associated with their abortions. This strategy involved writing, art work, and a ritual gathering. Sinead used writing to validate and honor the power of taking away the potential life and to express her emotions arising from exercising such power without feeling shameful:

> I actually wrote the story of doing my own abortion. I put that right down in black and white. I had never even thought about it. I still cry when I talk about it because it's so profound, you know. Such power to give or take away a life.

Correspondingly, Olivia "used to write quite a bit." She remembered "writing that all mothers ought to face this decision seriously that they are consciously going ahead or not going ahead with their pregnancy to understand the gravity, the responsibility of being a mother." Olivia utilized writing to justify her abortion, in addition to expressing her feelings and emotions. For Sinead, art work was another way of enhancing healing. She made an "amazing collage" to honor the "little ghost" that let her know its "little cherub's face" in her dream: "I don't have that dream any more." Finally, Sinead and Catherine utilized ritual gatherings that provided a supportive environment in which painful feelings and emotions were openly acknowledged and validated. This notion is illustrated in the following quotations:

> Most women that came had actually had abortions, but I didn't know that. That really helped, because there is something about the truth [that] will make you free. Speaking our own truths allows other people to speak theirs. It was amazing; it was the most amazing process. I consciously gave myself that time to work it all out. So the evening of the ritual was nothing more that just showing the collage that I had done and just talking about abortion. We just shared a few things and lit some candles, but it was incredibly healing. (Sinead)
>
> There was a number of us, and we all got together one night. . . . We lit candles, and we basically said farewell. . . . There were many different women . . . [with] many different concerns [including abortion, hysterectomy, and tubal ligation]. So that was a very specific way of saying your farewell that [was a] certain part of healing. (Catherine)

A ritual gathering enhanced disclosure of guilt and shame springing from the experiences surrounding the abortion. For example, Sinead discovered that the other women participating in rituals "didn't feel any less shame and guilt and concern than I had." Correspondingly, Catherine commented that "rituals are a very good [milieu for fostering healing]. I have done that before. That's a farewell that you have to make; you have to acknowledge what it is that's happening."

Another strategy that brought about closure of the grieving process was demonstrated by three participants. Catherine and Ashley held a dialogue with their fetuses to end the relationship in an honorable and peaceful way prior to having their abortions:

> [I] gave a recognition and farewell to [the Being] with a candle. . . . I [made] a very conscious effort to communicate to the Being that was part of me, and to come to a meeting [with] a conscious awareness. . . . It was a farewell, it was a conscious farewell. (Catherine)
>
> I'll see you in another time. . . . You just go away right now, little spirit, because I can't be your mom and I can't go through with this, but you will come back to me. (Ashley)

Reka honored her loss by asking for and granting forgiveness: "I was [often] praying and apologizing . . . [to the child-to-be] for denying him life." She located a safe place for [the spirit of the child-to-be] beyond the corporal world. Indirectly, this notion was expressed in her comments: "I still believe that the human being who was aborted is . . . somewhere. It's like I have my mother, friends who have died, and they still exist for me somewhere."

Similarly, more than 20 years later Sinead visited a cemetery, and put "roses from my ritual onto the family graves" to facilitate her healing. Acknowledging this loss and the emotional wound from others' reactions can be difficult, but the healing process provides release from this painful feeling: "Healing was not a bad wound; it was not life threatening. Healing in the physical sense was very clean, sort of a farewell" (Catherine).

Shining the Light: Breaking Away From the Shadows

The hallmark of this empowering phase (Figure 3) was the participants' growing insight that governed their awareness raising. Shining the light of insight included searching by the participants to broaden understanding of the external forces acting on their experiences. The metaphor "breaking away from shadows" was used to indicate the process of coping with negative emotions—the emotional residue from negative reactions of others. In this process the women refused to be influenced by negative cultural attitudes while continuing to heal. To attain a broader understanding about difficulties that shaped the abortion experience, the participants shifted the perception of their experience from the private to the cultural and societal realm. With an increased awareness, the women became empowered to make their painful feelings visible and their voices heard. This coping mechanism encompassed the following: recognizing and externalizing negative emotions, exploring their root cause, reclaiming the right to choose, asserting the right to act upon the decision, and accounting for their abortions. The data illustrate that a substantial number of the women experienced negative feelings and emotions following abortion. These emotions often included anger, guilt, shame, and fear. Despite their negative flavor, these emotions enhanced the participants' coping. That is, when acknowledged, they increased the participants' intellectual understanding of their painful experiences. This intellectual understanding inspired constructive problem solving or solution-focused healing. Accordingly, emotion and cognition working in tandem enlightened the women's awareness, thus promoted their healing.

Motivated by their enlightened awareness, the participants explored the myths that caused difficulty with their experiences of having an abortion. In abstraction, shadows represent a socially based threat to self-image and self-esteem. By recognizing the shadows hidden in the image of themselves, the women gained a greater understanding of the root cause of their negative feelings and emotions. Empowered by this awareness, they refused to be judged according to patriarchal moral values. With such attitudes, the women liberated themselves from the impact of society's hurtful insinuations about their well-being:

> To have people calling you 'Murderer,' my God, that's terrible; and I'm really, really angry at these people. Murder doctors, and they're out making [women's] life miserable. Many of them are men. (Paula)
>
> I just wish more women would be more up front about [the abortion experience], and I wish more men would keep their mouths shut and keep out of it. . . . They [donate] the sperm; they don't want [to assume the childbearing] responsibility. So if they don't want the responsibility, why should they have any [voice] in say[ing] what you [should] do? (Caroline)
>
> [I] really have a problem with people, men usually; you don't hear too many women saying this: "Well, she aborted a baby." Well, excuse me, if it's full term, it's a baby. In the first . . . few weeks it's an embryo; then it's a fetus. It's not called a baby until it's born, right? Let's face it, . . . an

> abortion in the first trimester, it's a fetus. It cannot live outside the womb. (Caroline)

> [Abortion] wasn't to the point where I thought, Okay, I'm a total murderer or killers. . . . It's to the point where, yes, there is a sense of loss and regret, but it's not something that I've done wrong. It's something that I've made a choice for. (Amanda)

By linking the private domain of their choice to the public arena, which has social and political dimensions, the women became more cognizant of the hidden agendas of patriarchy. One of these agendas includes a voyeuristic relationship with death: "Shadow of a nation—voyeurism—obsession with violence/death [on the television screen], but avoidance of real death issues" (Sinead). A nation that values quality of human life and protects women from violence and children from suffering also allows women to exercise control over their lives. A society that lacks an adequate understanding of the issue of choice becomes judgmental and fearful of women's power to control their own lives. Such a society violates women's freedom by "forc[ing] them to have children against their will" (Sinead). In order to avoid becoming objects of judgment and condemnation, the participants acquired a broadened awareness and became inspired to speak out on their own behalf. They spoke out for the freedom to make choices and be respected for making them.

Each participant asserted that she was responsible and accountable for her own abortion. That is, each woman viewed her choice as a rational response to the context of her life situation. Accordingly, her decision to have an abortion was appropriate even though it was "a very stressful decision" (Caroline). Furthermore, the women emphasized the importance of having the authority to make and safely act upon this "very difficult choice" without the influence of others. For example, Catherine claimed:

> Abortion, it's a very difficult issue, but then anything that has to do with life and death is. Nobody knows what the right or the wrong is. We can only deal with [what] is part of your own life. There is no way you can make sweeping statements that apply to everyone across the board; there are so many different aspects to it. . . . But what you can do is to make sure that [women] act upon [their choice] with the minimum life-threatening scenario.

Once armed with broadened awareness of cultural injustice aimed at controlling women's lives, the participants acknowledged accountability for their choice. By voicing their opinions against cultural injustice, the women warded off incriminating societal allegations aimed at hurting their self-image. As Amanda contended:

> I'm happy with [my choice]. I'm content to the point where I know [abortion] was not something that was wrong, that was nasty, that was dirty, that was something that should be a taboo and never be spoken of. . . . That is the way ignorance and racism [come]. . . . It is ignorance if you don't know [what it is] like for you; . . . you can't understand it." (Amanda)
>
> It's so much a choice, and in this country there's Pro Choice, there's Pro Life, and there're people who are dead set against abortion. All I have to say to them is, "You do not live in my shoes, you do not have to live my life, but until you do, you have no [right to say what I should do]." I think there is no reason to inflict on someone's freedom of choice. That's what it is: It is a freedom of choice in this country, and abortion is not treated as such, which it should be because there are so many children out there that are unloved and unwanted. (Amanda)
>
> I personally don't feel empowered by [having access to abortion]. This is something that frightens me, because I don't feel as though my life should be in the hands of others to the degree that they . . . say to me that I should have to have the child when I am not financially or emotionally ready for one. . . . I feel somewhat angry. (Christine)
>
> What's the best thing to do? Completely restrict a legal, ethically clean procedure? Is that a better thing to do than have people use a rusty coat hanger? What's the better thing here, because [a return to clandestine abortion] will happen. (Catherine)

Similar feelings were echoed by Bev. She recognized that "social policies against abortion" served "political interest," resulting in impoverishment of women and children: "what they [mothers] can offer [to their children]. When you cannot put food on the table most of the days, why [would] you have another child when you have already three or four to serve?" (Bev). With her insight, Bev exposed the shadows of her culture that confine women's reproductive freedom by using "social policies" that benefit the patriarchal establishment. Women are expected to have "a lot of children, so [the government] put in place awful laws" (Bev). She resented the imbalance of power:

> In a way you are mad and angry because of the other people around you. You feel like you have no longer control over your body. I mean, who are they to decide I should have four children? Who are they to decide what to do?

Correspondingly, Ashley recognized the impact of the status quo on her life; and, consequently, she cast off the shadow of glorified motherhood:

> All the fairly tales and all of that, oh, it's going to be such a marvelous thing [pregnancy]. And then when it happened and I wasn't ready for it, it was just such a loss. . . . It was that, "Wow! Here's this moment that society told me is supposed to be so wonderful, and it isn't for me at this time," so having to sort of say good-bye to that myth. For me it wasn't real; it was going to be a myth that first time. I chose to just say good-bye to it.

For Barbara, it was the social restriction on abortion compelling her to procure an illegal abortion rather than the abortion itself that affected her self-worth:

> To do an action like the abortion, it completely changes the good person that you are. It can change your concept of what you are capable of doing. That probably was the biggest psychological creepy thing, because, I mean, how do you handle that? How do I handle the fact that I sneaked off to the States and had an abortion?

Paula pointed out the social injustice of not having "a choice to make a choice" in terms of having the opportunity to say "I don't want to go through this pregnancy." Consequently, because of the restrictive abortion policy, she was unjustly thrust into the "underground" to obtain an abortion. "In fact, if [restrictive abortion policy] ever comes again, that's exactly what will happen again" (Paula). Several other participants also expressed concern over such risk, a "coat hanger aura" of clandestine abortion: "Even though we've made a lot of progress, we can lose it all" (Reka); "the possibilities for women losing their rights lurk under every rock" (Sinead). To forestall the reoccurrence of a secret abortion era, "we need to speak our own truth to maintain open doors for other women" (Sinead).

Christine had a choice not to have a child when she was financially and emotionally unprepared to become a mother. She was grateful for having the opportunity to obtain an abortion in a safe, supportive environment. However, from her viewpoint, she was granted a privilege rather than the authority to act upon her choice:

> I was so grateful [that] at the present time the others were allowing this to take place. I would've felt, at the time, helpless if society had said to me, "You can't do this." I would've felt horrible, because then they're making a decision for me, and they don't know me. They don't know what's right for me. So I feel as though I'm in the hands of [others] and just grateful that right now [abortion] was available to me.

For Ashley, such a privilege was eventually granted, but in a disrespectful manner, destructively affecting her self-esteem:

> [I have to] become a good girl to get this surgery, and that made me so angry. I . . . really messed up with my pride because I had this surgery and ended up being so angry at the people who gave health care . . . for a year or two after [the abortion].

Several participants acknowledged the misrepresentation of women making the decision to abort. They spoke against that stereotype by stressing that women are responsible for making their decisions. This was illustrated in several comments: "People think that [abortion decisions] are made in a cavalier fashion, but I don't think they are. Some of it is societal, but some of it is just an inner, innate thing that women have that we don't do these things lightly" (Sinead); "As a rule, I think women do not make this decision lightly. I think this is a very stressful decision" (Caroline); "You can't make [decisions] lightly because it's about a life; it's about your life and other lives" (Catherine).

Correspondingly, several participants spoke about the ambivalence they experienced while making their abortion decisions. Such ambivalence often indicated the women's heightened moral awareness that dismissed dichotomous thinking: "Ambivalence is a clinical term" (Sinead); "I think that's okay, to be indifferent. If it's black or white, then there's something wrong. [We] need to accept the gray area" (Ashley); "That is the patriarchal way to make the decision: not discuss it, and get on with it" (Reka); "Women need to roll [the decision] around, think about it. You don't want to have [a preconceived idea] of what is right or wrong with no references to your circumstances" (Reka); "To endure the antagonistic voices, it's like a willing sacrifice of clarity for a while" (Sinead).

In addition, Sinead became aware that women are hard on themselves while trying to adhere to a typically male style of making decisions:

> I think it [ambivalence] is one of the areas women are most criticized by ourselves, by each other, and certainly by the world at large. You know, we value so much that John Wayne image that "My God! I'm strong. Make my decision and get on with it, and then forget about it," which is what I tried to do.

From Paula's perspective, women who have had an abortion are conditioned by societal opinions into becoming depressed: "Why women get depressed . . . I say is because they think they should. I think it's like prescribed behavior."

Within the context of women's personal stories, shining the light of insight helped them gain a broader understanding of the external negative forces acting unequivocally on their experiences. According to the data, the culture in which a particular woman lives could shade her experience with negative feelings and emotions. With broadened insight, the women distinguished layers between their true selves and the internalized motives of others. Empowered with this knowledge, the women developed the ability to speak their voices against social imbalances that compromise their values in order to keep them in subordinate positions.

Stage Three: Becoming Whole

During the final stage the women acknowledged the possibility of personal growth as a result of effective coping strategies with the abortion experience. In this stage, strengthening oneself was the underlying process in a journey of becoming whole. In the context of this study, becoming whole meant developing a strong sense of oneself as an autonomous, knowledgeable, and worthwhile individual by constructing a positive image, accepting and understanding the Self, while developing deeper compassion for the Self and others. A strong sense of oneself was also established by gaining new insights that resulted in meeting personal growth-oriented needs that changed the attitudes toward others. By transforming themselves, the participants became "more goal oriented" and more confident and independent in creating fulfilling and meaningful lives: "[I] became more [assertive] after this very direct change. I was able to do my life [the way] I wanted.

. . . My life meant more to me, and [I] replaced [the loss] with something different" (Catherine). The participants developed greater appreciation of their lives through setting healthy boundaries and establishing reciprocal relationships with others. Finally, self-enhancement was accomplished by sharing direct knowledge and wisdom with others. This stage encompassed two phases (Figure 4): (a) looking for common ground, and (b) harvesting: acknowledging benefits.

Looking for Common Ground

Looking for allies or common ground refers to identifying other women who have been through similar or more difficult experiences and therefore possess knowledge that might positively influence the participants' closure of the experience. In this phase, the participants employed two strategies (Figure 4) to develop a sense of normalcy, acceptance of themselves and confirmation of successful coping. These strategies included (a) comparing themselves to others who coped with the abortion experience as effectively as or better than the participants, and (b) connecting with others who were less fortunate and at a bigger disadvantage. In this phase the participants also endowed their experience with special importance. To endow the abortion experience with moral and psychological significance, the participants explored new meanings, often by weighing their experiences against other difficult choices.

Comparing to Others

Comparing themselves to other post-abortion women who were coping as effectively or better than they were was another coping mechanism employed by the participants. Although searching for a better self-understanding was the underlying theme of this strategy, the participants often developed a deeper empathy for other post-abortion women, in addition to gaining self-acceptance.

Barbara compared herself to other women who also overrode family moral values in opting for an abortion. This coping strategy resulted in healing her wounded self-worth when she realized that she was not alone in repudiating family values:

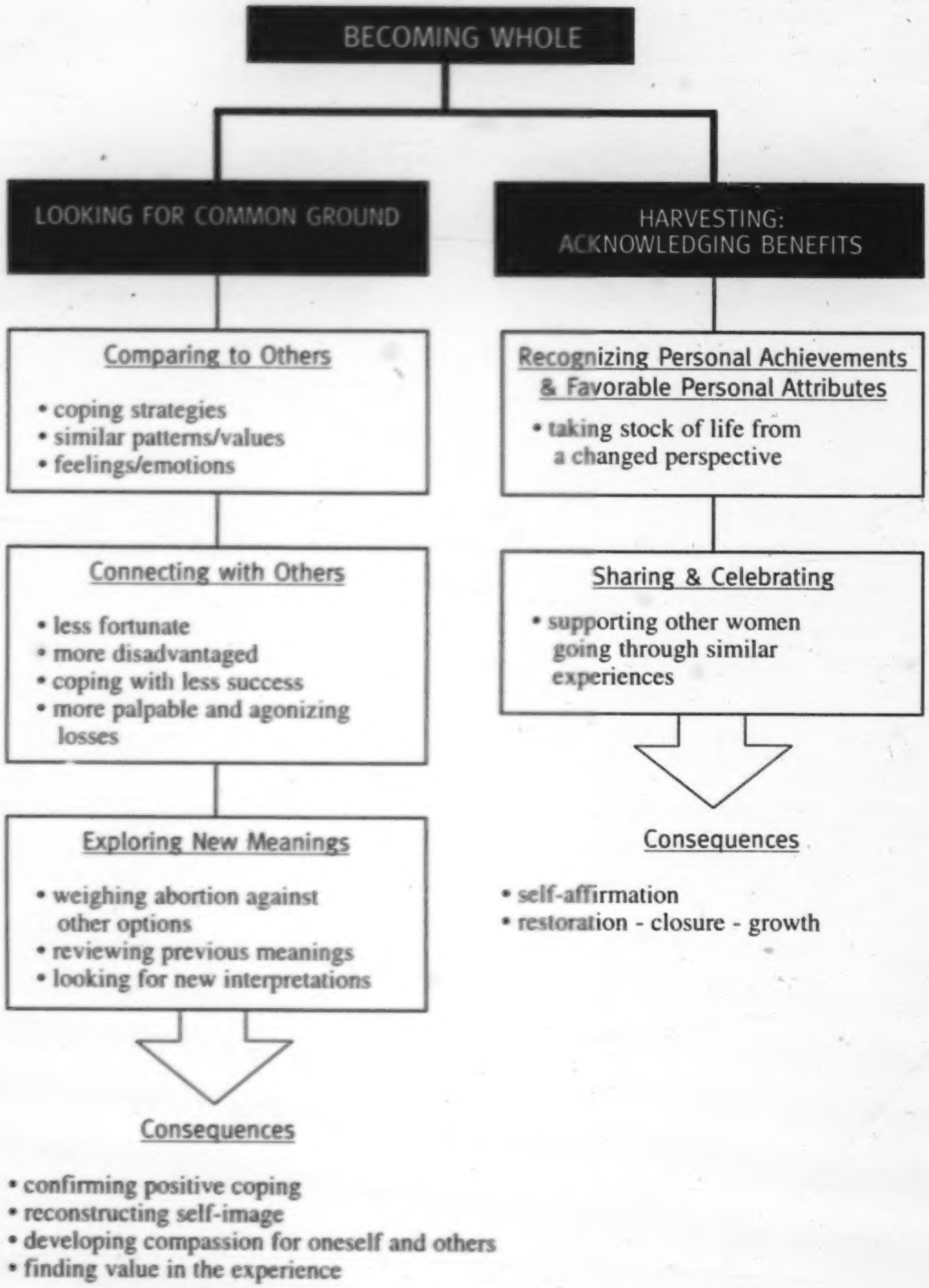

BECOMING WHOLE
LOOKING FOR COMMON GROUND
HARVESTING: ACKNOWLEDGING BENEFITS
Comparing to Others
• coping strategies
• similar patterns/values
• feelings/emotions
Recognizing Personal Achievements & Favorable Personal Attributes
• taking stock of life from a changed perspective
Connecting with Others
• less fortunate
• more disadvantaged
• coping with less success
• more palpable and agonizing losses
Sharing & Celebrating
• supporting other women going through similar experiences
Consequences
• self-affirmation
• restoration - closure - growth
Exploring New Meanings
• weighing abortion against other options
• reviewing previous meanings
• looking for new interpretations
Consequences
• confirming positive coping
• reconstructing self-image
• developing compassion for oneself and others
• finding value in the experience

Figure 4. Stage Three: Becoming whole.

> The other thing that . . . probably happens for a lot of women that happened for me, . . . I was one of [many] grandchildren, . . . very highly thought of. To do an action like abortion completely changed the good person that you are.

By comparing herself to another participant's perception of sexuality, Sinead acknowledged the impact of negative stereotyping of women's sexual behavior on her own well-being. Upon learning from another participant that she also was intimately involved with a man without a long-term commitment, Sinead decided to change the attitude toward herself. This change helped Sinead refrain from punitive self-appraisal, thus leading to self-forgiveness:

> We are so unkind to ourselves. I [thought] what a jerk I was because I was with somebody I would never have married. What a fool you are! What are you, some kind of a whore or something? It's so sweet to hear your thirty-one-year-old saying he wasn't the right guy. Not beating yourself up about it.

Catherine, who is "a [good] parent," compared herself to other women who have had abortions, but later became caring mothers. Although not directly stated, such comparison seemed to reinforce her image of being a woman who made reasonable and responsible choices regarding motherhood:

> There have been choices made . . . for having children . . .by some friends that have had abortions: "This is what I'm going to do now." [They were] very clear about [choosing motherhood], and I've seen them become quite remarkable mothers.

Several participants compared their feelings with those of other women who had had abortions. By identifying themselves with other women experiencing similar feelings, the participants achieved a sense of normalcy and developed compassion for themselves and empathy for others. In turn, this provoked further reflection on the impact of the abortion experience on one's life:

> My God, there we were, . . . women. The oldest one there other than me was ten years younger than I am. . . . So I guess my point is, they didn't feel any less shame and guilt and concern than I had. (Sinead)
>
> I mean, we just talked about how it wasn't sort of—I thought my child was a boy, and she thought hers was a girl. You knew what it was. When she

> told me her experience, yeah, I don't doubt [that] it . . . was my experience. You just knew that it was this or that. (Reka)
>
> I guess I can really empathize with any show or TV because you refeel it, you refeel it. There was just a movie on TV "Behind the Walls." I watched that, and I thought about what those women had to experience in making their decisions. . . . So I got more focus on how [abortion] affected my life. (Yolanda)

When comparing themselves to others with similar patterns of coping, Reka and Sinead acknowledged that they were normal in selectively sharing their experiences or keeping them secret:

> You just know somehow you're in one circumstance, and you know you make one big revelation [by disclosing your experience], or they think that they are making big ones. Big deal; I had one of those. (Reka)
>
> There are a lot of them that had abortions and never talked about it. It happened and it has never been talked about because they were not allowed to talk about it. You just know the pain of all those old people. (Sinead)

Connecting with Others

Comparing oneself to others who were less fortunate or more disadvantaged accounted for another coping mechanism. Once the participants better understood the experiences of others and developed compassion for them, this experience enhanced understanding and compassion for themselves. Understanding and compassion for themselves and for other women coping with similar and/or other difficult experiences brought about a sense of symbolic connection with the larger community of women. Such a connection seemed to facilitate empowerment and personal growth, in addition to enhancing the abortion resolution.

Comparison with others who had coped less effectively with their abortions caused one participant to feel confused about her sense of normalcy:

> I watched some television programs about how people were emotionally affected by having an abortion. I felt confused about their emotions . . . and wondered why I didn't feel as emotional as they did. . . . I [wonder] . . . where this deep, deep emotion and grief [is] coming from, and I just find myself feeling confused about that. . . . I've often thought to myself, I wonder why I am so different. (Christine)

By contrast, the majority of participants felt better off when they compared themselves to other women who seemed to be coping with less success. Paula used several ways to compare herself to such women. For Paula, this kind of comparison enabled her to validate her successful coping:

> Sometimes people talk about the terrible trauma. . . . I didn't have too much of that. . . . When I read today or a lot of people talk about the grief they went through and the loss, I truly didn't. It was mostly, thank God. I couldn't have faced to be pregnant. . . . You talk to many women, and that was the worst thing that ever happened to them. Some of them have never recovered. So I don't know about that. That's how I experienced it.

By comparing herself to other post-abortion women who coped less effectively, Catherine recognized her personal predisposition and strengths as gifts in successful coping. Unlike Christine, she established the reasons that caused difficulties for others with coping and developed a better understanding of their less-effective coping strategies:

> I know there is a lot of women who felt guilty about [their abortions]. I don't understand it myself. It seems to me that's how [they are], and I'm not like that. You have to take responsibility for the choice you make. . . . If you [don't] take responsibility, maybe that's guilt, and [some women] are avoiding that, so they feel bad. That's guilt. I've never felt guilty about what I've done, and it's not because of my upbringing. It's just because you are born with certain gifts. . . . [I didn't feel that the abortion was something] that I have to drag around with me; I've dealt with it. . . . [For others], you also have to take into account what your upbringing was, what type of moral atmosphere you grew up with, and how much you adopted those [values] as your own.

Other participants compared themselves to women whose abortions were performed in more difficult situations. This comparison resulted in feeling better off or luckier: "I know many of those women would've had abortions, no question about it. And my mother's best friend died of a botched abortion" (Sinead); "A lot of women died of infections and bleeding in hospital" (Bev); "I did this alone, by myself. . . . So in a way I reduced the risk of infection" (Bev); "I'm lucky [that] I didn't have to go into the back alley, as they talk about these seedy places where women get sick and die. Many died from that" (Paula).

Bev also found that she was better off when she compared herself to other women having abortions with more advanced pregnancies:

> I still think it makes a lot of difference how advanced your pregnancy is. Mine was not advanced, so I didn't have to see the child, let's say, because . . . I would have felt remorse, I think, because it's something else, hav[ing] it in the first month [rather than] hav[ing] it later. I think it made a huge difference. I know from my friends [who were pregnant], let's say, three months, . . . and you see the child. They really felt bad about it. But that was not my case.

When comparing herself to women whose losses were more palpable and agonizing, Olivia felt fortunate to be able to bear her abortion as a personal loss. Then, in turn, she could offer deeper levels of compassion to women in situations similar to hers:

> I don't think I could deal with . . . a child dying at birth. That would be probably just the most terrible, terrible thing. [With] an abortion you're so far away from that whole relationship— . . . "Gosh, here I am here, and the sense that I have here and there." It struck me as a terrible, terrible thing to happen, to bear, I guess. Made me think a lot about [the] suffering of women.

Finally, by comparing herself to another woman who experienced hardships raising her newborn, even though her partner shared the childbearing responsibility, Ashley reaffirmed her choice:

> We were two young women, and we made two different choices, and I'm really happy for her, you know, the way it's worked out. I think it was very hard for her. For me, I just couldn't have [a child]. I mean, she had a partner [who supported her during pregnancy and shared the childbearing responsibility]; I couldn't have imagined doing it alone. It's not unpleasant [to think that I could have had a child as old as hers if I had made a different choice].

As derived from the data, social comparison helped the participants validate or reconstruct their self-images, resulting in self-acceptance in addition to feeling empathy and compassion for other women. Compassion for themselves and for others generated strengths and broadened the participants' understandings about what women have in common while facing a variety of experiences and concerns. This empowering strategy enabled the participants to achieve resolution of the experience more readily in having an abortion.

Exploring New Meanings

By employing this strategy (Figure 4), the women reviewed psychological meanings of their abortions and the losses associated with their experience. With emphasis on the psychological significance, the participants often developed new insights that facilitated the acceptance of the experience. Through this acceptance, they found contentment and were able to move forward to closure of the experience. For example, Sinead allowed herself to name the aborted fetuses "the little ghosts," after discovering that term in literature. Being "a feminist, for God's sake," Sinead believed that she was not supposed to perceive the fetus as a loss: "I had never allowed myself to think of these babies as babies, of course." Furthermore, the meaning of the aborted fetuses led Sinead to create the meaning of the abortion:

> That was helpful to think of them as little ghosts, and the other thing that was very helpful for me was more that it was the abortion of a natural process. It was something that was going on in my body that was not allowed to come to completion.

By reflecting upon the phrase from the Bible "the Lord giveth and the Lord taketh away," Sinead discovered that abortion—the symbolic act of "tak[ing] a life"—was morally right. This new meaning brought her consolation: "I've always taken comfort in the fact that if there's a way in which I could do my own abortion, then I just know in my heart that it can't be wrong." For five participants, acceptance of abortion as a symbolic act of "taking a life" inspired reflections upon the meaning of death and loss. They perceived death as a transcendental mode of a new beginning—the "rebirth." With such awareness, the women endowed the loss with new meaning that brought about closure of the abortion experience. For example, Reka stated: "My last integrating experience was getting a dog." She believed in "the incarnation of this lost child," whom she "knew intuitively was a boy, and his name was Ira. . . . I named [the dog] Ira." Sinead found her artistic creation was a metamorphosis of the pregnancy loss and the loss of biological ability to create: "[Because] I'm not going to give birth to children anymore, . . . I give birth to some paintings."

For Ashley, Olivia, and Catherine, cogitation over the abortion experience in relation to a life/death cycle resulted in new meaning to their sense of loss: It was a way of saying "good-bye/hello." For example, Catherine said: "[Abortion] was a farewell; it was a conscious farewell [to the being]. . . . I have . . . children now, and it was a hello, and it was a greeting I was able to continue [with my pregnancies]." Ashley, who "had a strong sense" that the relinquished fetus "was a boy," stated: "It's sort of some kind of reincarnation thing where you go back to limbo for a little while, and then my next child was a boy."

Similar meanings pertaining to the loss of a fantasy baby were illustrated by Olivia. She and her partner "often think that [the present child] would not be there if not for this other sacrifice. . . . It's almost as if his presence wanted to be. . . . It wasn't the same child, but I can't help but think that there would be no Alice had we gone ahead with this other child" (Olivia). While reviewing the meaning of her abortion, Olivia weighed this experience against another one: "I was very close to dying, and the points where [both experiences] intercept are quite similar" in terms of saying, "It's okay here. There is something else beyond that."

A similar strategy was employed by Yolanda, who weighed her choice against euthanasia. Although not explicitly stated, this approach helped Yolanda deal with the uncertainty associated with the abortion choice: "You will always probably toss about [abortion]. [Abortion choice] is probably very much [similar to euthanasia]; we've had to deal with it three times; do we pull plugs on life support?" Yolanda employed this strategy to cope with her guilt:

> There isn't a lot of guilt or shame to this day. . . . You can [still] weigh it back and forth. . . . You will still feel guilty when you pull the plug on the life support machine. There is probably guilt associated with [euthanasia] that [even] the doctors and the [nurses might] feel.

Amanda acknowledged the fact that "in life there are some very, very hard choices that you have to make in order to go on. . . . It was the best choice I could've made at the time, and to this day I still don't regret it. I will never regret it." By the same token, Caroline viewed her experience as "a piece of you that will always be there in our lives, [like] with everything we do in our lives, whether they're good or bad." Barbara "occasionally" looked back at her abortion to review the meaning of the loss associated with her experience: "[I] do consider what it would be like to have a son or a daughter that age." Shifts in perception helped her detach herself from the loss and, consequently, to view the fetus as a threatening agent to her health:

> I probably wasted a lot of my life being apart [from] myself, possibly much less of a reason than I needed to. . . . I do seem to think of [the fetus] a lot as to what it did to me rather than what [it was].

From Barbara's previous understanding, abortion meant the act of "ending [a] life." Now, she perceived abortion as a symbolic ending of a poor relationship rather than ending a life: "It was a symbol of our relationship and my feelings that he wasn't good for me." Finally, Barbara, like Reka, recognized that, at the time, abortion was the best alternative to her situation: "[The abortion], it's always with me, but it's not something that makes me think poorly of myself at this point because we do learn to at least have some understanding . . . that we do the best we can." Paula wondered about "how it would've been" having more children, but at the same time she was glad not to have more: "Then I think, Thank God I didn't. I have enough to do with [two] of them." Similarly, the other women reflected upon their abortions and wondered about the child-to-be. Without evoking grievous feelings, they perceived this reflection as "a natural thing, sort of a reminder of that time" (Catherine). As Christine said, they "placed [the abortion] in a place that is peaceful."

Occasionally, such reflections caused some emotional discomfort for Christine, who had had the abortion more recently and considered having a child in the near future: "[I] may have a tiny flicker of what could've been . . . for the child that was there. For the most part, I think . . . I'm at peace with it, and I just have to live my life day to day and pull out of it what is good." For Caroline, "it would be abnormal if you didn't" reflect upon this loss: "I give myself a mental shake and say, 'What's the point. Why think about that, because you can't change it'" (Caroline).

For each woman participating in this study, the abortion experience had a profound influence on their personal growth. This growth was inspired by the women's courage to restore their sense of wholeness after being destroyed by the crisis of unexpected pregnancy. Through acceptance of the experience and personal growth, the woman achieved a sense of wholeness and fulfillment. This notion was reflected in several comments: "In the end that experience is not just something that happened. It became a part of me; it made me who I am. . . . So it was my entrance, I guess, into the fullness of motherhood in my mind" (Olivia); "That's part of who I am" (Catherine); "That's part of my history. . . . It's part and parcel of who I am" (Caroline).

Harvesting: Acknowledging Benefits

Finally, the growth toward wholeness was expressed in personal development. This development was considered by the women studied as the ultimate worth after going through the abortion experience. When evaluating personal accomplishments, the participants often recalled the reasons for their abortions. Correspondingly, the participants acknowledged the development of favorable personal attributes while coping with the experiences associated with their abortions. By acknowledging personal accomplishments and positive personal attributes, the participants reclaimed their abortion experience as a significant life event that fostered their ongoing growth. They also developed trust and confidence to function to the best of their potential in meeting other challenges in an unfolding process of growth toward greater wholeness. In this process, the participants also found contentment in reaching out to help others. Finally, the success of meeting personal goals and personal development maximized the women's sense of empowerment. The participants acknowledged benefits by employing two mechanisms: (a) recognizing personal achievements and favorable personal attributes, and (b) sharing and celebrating.

Recognizing Personal Achievements and Favorable Personal Attributes

This strategy was used to assess the implications of having an abortion in order to (a) reclaim the reasons for the abortion, and (b) to find value in going through the experience. By acknowledging personal achievements that resulted from having an abortion, the participants reaffirmed their choice, thereby achieving a sense of closure to the experience. By considering the circumstances surrounding her life, Reka recognized the strength that had been necessary to make a difficult choice:

> I feel compassion for [myself]. . . . I don't feel any regrets. I don't believe I did a bad thing. I believe I did what I had to do, when you consider all of the factors involved. I feel like maybe I made the right choice.

Barbara recognized that having an abortion was a blessing because it afforded her the opportunity to have children when she was prepared to care for them with affection. She recognized the personal achievement of becoming a devoted mother, which parallels Catherine's sense of achievement in becoming a responsible parent:

> I feel so blessed with my children, I feel for the most part that I've good energy and good loving and that I made a decision like that to have an abortion and making up for it very much—not that I have to make up for it, but I know because of having made that decision I've got . . . children that I've planned to have or feel to encompass in my life in a very loving way. (Barbara)
>
> I did the right thing. Yeah, I have no regrets, and I believe . . . I'm able to give my children now a better life. . . . I do believe that when I did choose to have my children, . . . it was a very conscious choice. I was able to be a better parent. (Catherine)

Paula acknowledged the benefits of her abortions while also reconsidering the welfare of her existing children and extended family: "Would I have done anything different? No, [I would not] in those circumstances. . . . What was I doing to my children and to my family? . . . It was absolutely the most relieving and happiest day [when] I could terminate those two pregnancies" (Paula). Yolanda also came to know the value of her experience: "It gave me momentum to reach my goals because I had given up something so that I could continue on the path that I was going, and make sure that I implemented it." "It helped me to make myself complete." She also developed a transferable skill of using research in making other decisions: "I would be able to transfer that [knowledge] to other major decisions in the future."

Ashley came to know the value of her experience in increased self-confidence: "[Abortion] was the way to affirm my inner strength, [by] adhering to the decision while everybody seemed to be against me." Similar benefits from experiences in decision making were mirrored in Olivia's comments. She learned that saying "no" was the right thing to do. Saying "no" when it is good for the child is the first parental responsibility in setting healthy boundaries: "[I acquired] more ability . . . in my life as a mother to say, "No, . . . these are the boundaries on things" (Olivia).

In addition, two of the participants envisioned the impact of choosing an opposite alternative. This notion was reflected in Amanda's comments: "I am glad I made that choice, because otherwise I would be right now going through a court battle for custody." Furthermore, she felt her life would have been more stressful. The feelings arising from dissatisfaction with life might be projected on the child:

> I know the fact that I made the right choice for myself at that time. If I had made the choice to keep that child, it would've been a lot harder. My life, yeah, it would have been a lot harder for the baby to handle, because there would've been a sense of regret. But I had to get on with my life, and I would've taken it out on my child.

A similar coping strategy was utilized and similar feelings were echoed by Bev. She also recognized that if she had not had the abortion, the child would have suffered from the implications of not being welcomed by the mother:

> I really think if something would have happened . . . and I would have been forced . . . to keep the child, I don't think it would have been a good thing, because you think of the quality of life you can offer your child, from the fact that you don't want that child. I think it would be awful for the child after it is born. I really think that.

Personal confrontation with the decision to abort and courage in confronting the unknown provided the women with the impetus for their personal growth. With recognition of their personal development, the participants were able to build greater confidence in themselves and to develop greater sensitivity to others. Reka attested to this conclusion by saying: "Mainly the strength comes from having lived through the experience, not [from] an intellectual process." Barbara developed greater appreciation of her life through establishing reciprocal relationships with others and taking better care of herself:

> I went through a lot of people not taking care of me, or [I was] not taking care of myself. [This experience provoked] such personal reflection of people that you have in your life—how you choose to be treated and how you choose to treat your body.

Similarly, Amanda became more assertive in her relationship with a man, not allowing him to control her life: "I also learned [not to] be so easily trusting to a man, [n]ever let a man take that much control into your life. I don't allow it [anymore]." Paula came to know the value of respect for her body and the Self as an independent individual capable of succeeding in social arenas usually dominated by men:

> I had to take better care of myself sexually. I learned that I had strengths, . . . so that I could've continued to be involved in . . . more social life, more man dominated. If you don't have a man, well, who are you anyway? . . . That was such a good lesson that I knew you can't depend [on a man] as much. So I began to see men in a different light, . . . but I couldn't put the black hat on and say all men are bad and all women are victims.

Reka developed compassion for herself and others. According to Reka: "I feel compassion for the person who went through that [experience]. . . . Every experience, however bad, can increase your compassion and understanding." As a result of her own experiences associated with her abortion, Reka developed deeper understanding and acceptance of individuals with a different sexual orientation:

> I learned a lot from this experience that I transferred to other situations like people being gay. I did find, I believed they were wrong, [or] bad. When you go [through] an experience which before you thought was fairly simple and straightforward that you could know how you would feel, or do what's right or wrong, and then you find everything you believe stood on it's head. I really began to understand how complex, and ambivalent, specific to persons, what is right or wrong can be. How there is no right or wrong. I guess trying to learn to accept other people in all kinds of other experiences, just where they are, without any need for judgment.

Drawing on wisdom derived from her own experience, Yolanda learned to be nonjudgmental and to respect difficult choices of others:

> [I] certainly don't judge people that have to make difficult decisions; . . . abortion is very controversial, and . . . there are other subject matters that are controversial too. . . . [I] found myself reluctant to make judgment because until you are actually in that situation, you don't know what you will do.

Similarly, Bev, Ashley, and Olivia developed greater understanding and sensitivity for other women going through the experiences associated with an abortion. This notion was echoed in the following comments: "Women are different all around the world. You never know [what will happen]. Therefore, we should not be judgmental" (Bev); "I [learned] about how women are treated when they go through the abortion and how they can be made to feel so small" (Ashley); "Abortion completely turned around my impression of what that is like for others, the whole issue of abortion beyond the idea of choice, which I think is so critical; that everybody's experience clearly is very, very different from another one" (Olivia).

Sharing and Celebrating

After recognizing and appreciating the benefits of their experiences, the participants came forward to share their conclusions with other women going through similar experiences. They helped foster the ongoing coping and healing of others while at the same time honoring their own experience. For the participants, this strategy encouraged them to reclaim self-respect and simultaneously show compassion for other women. This reciprocal interaction of support and comfort was another form of personal empowerment that helped them progress toward wholeness.

Knowing how hard the struggle with the abortion experience can be, the women embarked on a variety of actions to help others go through similar experiences. For example, the women expressed hope that, by their participation in this study, their stories would one day benefit other women. This notion was exemplified by comments such as: "I'm glad [that] you are doing this study. . . . I hope that [the experience] isn't that miserable for people in the future" (Ashley); "It's wonderful that you give women the opportunity to speak of this [experience]. I believe that nurses need to hear these stories of the anguish and the long-term effect" (Sinead); "It's wonderful that somebody is doing something about this [experience]. It's great that . . . more studies [are] being done about it, because it's such a taboo issue in this country" (Amanda]. By "speaking your own truth," we can affect change in the social attitudes associated with abortion, "by just talking about [the abortion experience] and not being ashamed to bring it up. Then you hear other women say, 'Oh, I had one too,' so it becomes more acceptable" (Reka).

Reka was also one of the participants who, as a result of her experience, provided a nonthreatening environment for a woman faced with a similar situation:

> Again, the value of having an experience like I had was that I could be supportive to her. I could say, "Whatever you choose to do, I respect." I could respond to her without shock or horror; we could deal with it in a supportive, calm, and rational way, which pleases me.

Several participants observed that one outcome of their abortion experience was a contribution to other pregnant women's well-being:

> I was involved all the way down the line in helping her [gain access to the abortion services]. She loves me to this day. I'm sure she thinks I can walk on water. I can't, but I don't tell her I don't. That was a good decision for her. (Paula)
>
> I became a volunteer for the [agency helping women to deal with issues associated with childbearing]. I found that very therapeutic, [to help other women] going through that experience. It felt so good for me to be able to listen to their stories and to offer support to them for whatever decision they made. (Ashley)

Ashley's involvement in the Pro Choice movement and Catherine's involvement in Campus Pro Choice were two other ways in which contributions to the betterment of other women were displayed:

> I became very passionate about the subject after everything had settled. I was involved with the Pro Choice group. I was very passionate about it. I suppose that was a way to cope as well as to get around other people who had the same value system as me, to try and make a difference. (Ashley)
>
> [I] realize that a lot of [women] just didn't have all the facts. They didn't know what they were dealing with. So the whole thing with Campus Pro Choice was . . . that people get as much information as possible about [their choices]. (Catherine)

Furthermore, to help other women have a positive experience with abortion, Reka and Sinead expressed their desire to work as volunteers at the abortion clinic: "I've always thought about when I retire, [I would like to work as a volunteer at the abortion clinic]" (Reka); "One of the things that I have thought about in looking at retirement now and how to spend my time, I have thought about volunteering at the abortion clinic" (Sinead).

By talking about the positive outcomes and providing an encouraging perspective on the aftermath of an abortion, the participants helped other women go through similar experiences. In this process, however, the participants were able to help themselves by honoring their own experiences. For Sinead, the abortion experience carried an even greater significance. To address social injustice and to honor women's sexuality, she decided to paint and to encourage discussion with older women who have had abortions, but never were allowed to talk about them. Sinead expressed the desire to help the older women share truths about their abortion experiences:

> There are a lot of [older women] that had abortions and never talked about it. So I became very interested in that [issue], and when I did work around my own abortion issues, one of the things I resolved was to address . . . how important is that to [older women]. . . . So I felt as if I . . . honor[ed] my two little ghosts. . . . I'm going to encourage somebody else to study this [issue]. (Sinead)

It is not surprising that Sinead "started painting women on the cross." She explained; "[Women] are definitely crucified" for exercising the right to choose. With commitment to a new pursuit of creative self-expression, she produced additional paintings to honor the women's effort to establish their identities and development outside motherhood:

> There were two things that I vowed . . . as a result of working on the abortion [experience]. . . . One of them was that I'm not going to give birth to children any more, but I [am going to] give birth to some paintings. So one of the little vows that I made was that I would do two paintings. . . . [I] would ask a decent price [for them]. . . . [Currently], they're out in the world.

Evolving Empowerment: Utilizing Social Support

Social support, perceived as a critical need by each participant, emerged as a crucial source of empowerment necessary for the successful resolution of experiences associated with abortion:

> But dealing with it, you need a lot of support, you need a lot of friends, you need your family behind you if you can have your family behind you; if you can't have your family behind you, go get counselling, definitely, because it's a hard thing to deal with all by yourself.

As a contributing factor, social support magnified the participants' strengths and amplified the positive changes that had already been instigated by various self-affirming mechanisms that were discussed in the previous sections. The participants attempted to find comfort in the social support that was available to them throughout all stages of the abortion experience. However, as the data indicate, social support was particularly important for the women during the stages of surviving and healing. They utilized various sources of support that included their partners, family members, friends, and professionals. These are discussed in the following categories: (a) seeking assurance in partners and families, (b) reaching out to friends, and (c) opting for professional help.

Seeking Assurance from Partners and Families

As derived from the data, partners and families appear to be the most important source of social support. Reaching out to their partners for support revolved around three themes: sharing responsibility in the decision-making process, sharing feelings and emotions, and seeking understanding and reassurance. Because the partners' involvement in a joint decision-making process was already discussed in the previous section, this section will focus on illustrating further applications of such support. Based on the experiential evidence, women anticipating an abortion can be emotionally drained. During such times, women's emotional needs might become more complicated, thus requiring more sophisticated ways of providing emotional support. To ease the woman's emotional struggle, a partner who provides support can help a woman explore and ventilate her feelings. Empathic listening rather than logical reasoning might be the best way of providing comfort. In addition, some women might significantly benefit from the partner's apology. For example, expressions such as "I feel sorry for you, seeing you go through it" might ease the woman's emotional pain and resentment towards her partner.

Throughout this process, their partners' feelings and actions constituted the crucial aspects of emotional support that helped these women move from one place to another. As derived from the data, men responding at a strictly cognitive level create emotional distance and therefore do not meet their partners' emotional needs. They are unable to nurture and comfort them sufficiently in their journey of soul searching. Nevertheless, their partners' presence might be appreciated by women:

> So that whole night stands out in my mind; it just is an immense struggle. Martin was in the background writing something on a piece of paper, and it was like my struggle was too hard for him to enter into. . . . So anyway, I was glad for his presence there, and occasionally he would try to work out some intellectual argument with me. (Olivia)

Although in response to her emotional distress, Yolanda's partner encouraged her to continue with the pregnancy the night before the procedure, she opted for the abortion. Her determination to terminate the pregnancy was driven by the assertion that the abortion was "logically the right thing to do." Yet she experienced a great sense of sadness stemming from feelings of rejection from her partner. This sense of sadness was expressed in Yolanda's comments, such as: "He was quite devastated and said, 'Well, you know, we don't have to go through with [the abortion].' . . . [However,] I didn't feel he meant it at all." Therefore, she decided to carry out the decision, but she "never forgave [her] partner for not wanting the child. . . . There still would've been resentment in the sense of rejection."

In addition to their partners' emotional support, the majority of participants sought support from family members. Based on the women's experiences, family can exhibit both positive and negative responses to women's need for support. Those contrasting family reactions to women's need for support, and the consequences of such reactions, were clearly illustrated in the participants' comments.

Seven of the 12 women participating in this study were supported by their families. The women selectively searched for support from family members. Convinced that her family would not have supported her, Sinead did not even consider asking for support: "My family didn't know what to do with me anyway" (Sinead). Reka, knowing her mother's anti-abortion position, recognized that she should not expect support from her: "I didn't share it with my mother because my mother was fairly fanatically anti-abortion." Caroline did not divulge her experience to her family for a similar reason: "I never did tell my family [about my experience] because my mother was very anti-abortion."

Bev, for example, "didn't want to hurt her [family's] feelings," so she avoided adding an undue burden by initially hiding her experience from the family at the price of her own well-being: "So I felt guilty in a way, but I felt ashamed . . . because I had to hide from my family." In contrast, Ashley, perceiving that her well-being was at stake, took a risk in requesting support from her mother. She hoped that her mother would support her choice because "my mother had actually years before assisted another young woman to go through an abortion." However, Ashley did not receive support from her mother in spite of her well-thought-out scheme:

> I remember I took my Mom to a little pancake restaurant that was where I was going to tell her. I guess I was a little bit apprehensive about how she would be, so I wanted to do it publicly so she couldn't have a big fit on me. So I told her. I really thought she would be pretty understanding, but she wasn't. She was mad that I would do this; . . . I think she said I was murdering her grandchild.

In response to her mother's nonsupportive comments, Ashley was thrust into isolation and resentment: "So basically I cut her off during that whole experience. I didn't even tell her when I was going for it. I just chose not to have contact with her for a couple of months. I was angry." Then Ashley reached out to her brother for support for her choice to terminate her pregnancy. However, he did not support her choice, but acted against it: "My brother . . . just assumed that I would be having a baby. . . . I remember it was around Christmas time, and my brother got me a teddy bear for the baby." While searching for support, Reka "had unfortunately confided in a sister-in-law." Consequently, news about her abortion had spread to her "husband's family," who passed on their judgment: "My husband's family thought [that] I was evil, just totally evil." Yet, ironically, she hoped to gain reassurance from the family that she "was still an okay person." Moreover, the entire family compelled her into tormenting isolation for her lack of conformity to a family ideal: "Society around us considered me wholly responsible and that I had done a bad thing and my husband's entire family shunned me for a period of time. They refused to speak to me actually.

In contrast, several participants were more fortunate than Reka in seeking emotional support from her parents. Three participants gained approval for their decision to abort without any indication of condemning judgment:

> I had the support from my parents, I think, either way; but they certainly didn't make me feel like I was any less of a person if I had the abortion. They probably hoped that's what I would do. They didn't want to see me starting off at twenty with children. (Yolanda)

> My family also supported me as well, my decision. . . . It was nice that I had their support. . . . It was such a relief, and I felt so much supported by the people who had cared for me. So this was a great relief. (Christine)

> [M]y family was very well aware of it, and they backed me up a hundred percent, which I am very glad and grateful for, because if I didn't have that, I probably would've lost it, more than likely. (Amanda)

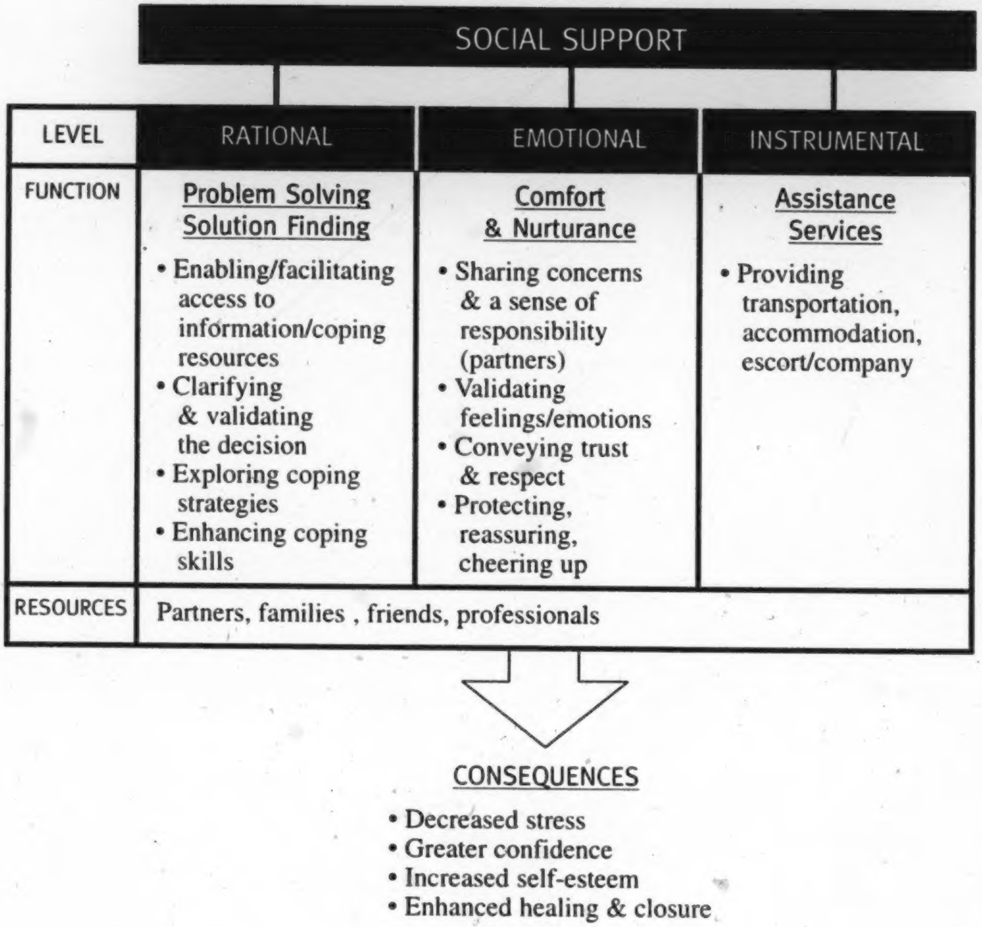
Similarly, several weeks after the abortion Bev told her secret to her mother, "and [she] was very supportive and very understanding. It was okay. I healed fast, not only physically but emotionally." For Amanda, the family's geographical closeness appeared to be significant for full emotional support:

> I wasn't so much worried about being a babbling idiot; it was the fact that at the time when I had the abortion done, I didn't have a lot of family support because my family lives so far away from me. I had a lot of friends' support, which was nice, . . . and I couldn't get home, so that was nice.

In light of the experiential data, family support constituted a crucial element for coping with the decisions around having an abortion, as well as the experiences that followed from these decisions. Supportive families essentially contributed to the women's well-being by enabling them to sustain their self-esteem and confidence in making the right decisions.

Reaching out to Friends

According to the data, friends constituted the third source of social support for women participating in the study. Excluding Sinead, the participants rallied support from their friends. Three women, Barbara, Paula, and Olivia, benefited from the instrumental support provided by their friends. For this study, ***instrumental support*** is defined as an application of tangible help; that is, of "acting for." For the participants, instrumental support (Figure 5) provided by friends helped them obtain access to abortion services. Their friends usually explored and built a network leading women to abortion services. This notion was expressed in the following comments: "I went to the USA to visit a



SOCIAL SUPPORT

LEVEL	RATIONAL	EMOTIONAL	INSTRUMENTAL
FUNCTION	**Problem Solving Solution Finding** • Enabling/facilitating access to information/coping resources • Clarifying & validating the decision • Exploring coping strategies • Enhancing coping skills	**Comfort & Nurturance** • Sharing concerns & a sense of responsibility (partners) • Validating feelings/emotions • Conveying trust & respect • Protecting, reassuring, cheering up	**Assistance Services** • Providing transportation, accommodation, escort/company
RESOURCES	Partners, families , friends, professionals		

CONSEQUENCES

- Decreased stress
- Greater confidence
- Increased self-esteem
- Enhanced healing & closure

Figure 5. The nature and impact of social support

classmate, . . . and it's from her place that I met a physician who gave me a name of a person who did abortions" (Barbara); "Someone was found out, a woman in Regina" (Paula); "I knew someone who had an abortion not so long before that, and she told me who I needed to contact" (Olivia). Providing transportation and company to the abortion services emerged as the secondary purpose of instrumental support that was offered to women by their friends. "I went with her, and we drove" (Barbara); "I asked my girlfriend; she came with me" (Paula).

Along with the instrumental support, friends provided women with emotional support (Figure 5), which was greatly appreciated by each participant. Comforting responses of friends could have been exhibited in various ways. Although the following responses were explicitly described by Paula and Olivia, they could apply to other women who talked about comfort obtained from their friends. For example, Paula's friends validated her decision to terminate the pregnancy: "I was surrounded by people who thought that's the only way." In Olivia's case, friends provided her with emotional space during the decision making and conveyed trust in her ability to arrive at a sound decision. Responses fashioned in a comforting manner helped Olivia acquire greater confidence in her own decision and boosted her sense of competence and her self-esteem:

> There was this one thing when I know I was making my decision, what helped me the most was those people who basically said they knew that I would do what was right for myself; just that they trusted me to come to the right decision. . . . That to me was an amazing thing, to just be given that space and respect.

The other women who were engaged in this study reported several other comforting strategies that were employed by their friends to help them resolve their experiences. For example, Bev found solace in her friends, who "were very inquisitive" and cheered her up by engaging her in pleasurable activities: "They said, 'Let's talk, let's go, let's do something." By the same token, Paula found relief in her friend's joviality: "She was a very, very funny lady. She could make you laugh." Unlike Bev and Paula, Barbara benefited more from being understood by her friends than from being cheered up: "I spoke to this good friend of my mine, Rebecca, who really catered to me. I don't think she could understand; she was one who was never able to bear her own children."

The opportunity to vent feelings and channel emotions also was reported by the women as a supportive milieu created by their friends. "I had close friends and I talked about it. I talked about [my experience]" (Paula). Being listened to and being offered affection and compassion appeared to be important ingredients of emotional sustenance anticipated by women who shared experiences with their friends. These components of emotional support were explicitly pointed out by Reka and Paula: "I mean, women, the women I knew were all very compassionate" (Reka); "He was very affectionate with me" (Paula); "A lot of caring around me, and I think that has a lot to do with people going through that" (Paula).

An interesting phenomenon that emerged from the data was that some men could be as compassionate as the women to women's experiences. Like Paula, Reka also experienced being cared for by men: "A lot of men I talked to were very compassionate." For Reka, validation of the experience rather than receiving understanding appeared to be the more important component of emotional support: "I don't know if they understood the experience, but they seemed to recognize the anguish I felt and to be very caring about it."

The women participating in the study were poignantly sensitive to their friends' social judgment. Some women were vulnerable to unspoken judgment even though they were surrounded by a selected circle of friends. This vulnerability is reflected in Olivia and Reka's comments: "My friends, when I was talking about it, I know a couple of them, I was quite worried that they were judging me, for the most part" (Olivia); " [I] had a few people in my life who listened and cared, but I think—I'm guessing—but I think they would say [that there was] a degree of judgment even in their minds" (Reka).

The data demonstrate that it was unusual for the women to find a network of completely supportive friends. In this study, only three women established a network of friends who offered them support without any indication of cultural judgment. Lack of psychological support and the risk of exposure to social judgment could trigger enforced isolation: "I just really was isolated. I didn't have my family there for support" (Ashley). Not having any resource of support for many years following the abortion, Reka experienced a profoundly agonizing sense "of abandonment of being left alone, totally alone in the world." Consequently, isolation could increase feelings of shame and guilt that were experienced by almost every woman providing data for this study. Additionally, Reka also experienced a sense of helplessness. This outcome might support the notion that abortion itself does not contribute to great psychological distress, but the surrounding circumstances do:

> I was surrounded by people who thought that's the only way. So I guess that way I never felt that I was doing something so bad. The people that I was dealing with didn't shame me at all. (Paula)
>
> Sad wouldn't begin to cover what you felt. Doesn't begin to cover the intensity of guilt, of not being able to get away from your thoughts day in and day out. Not having any support, not having anybody who told me I was still an okay person. (Reka)
>
> I felt quite helpless. Quite helpless. I felt a tremendous sort of religious or moral guilt. The trauma was that there was no one, really, that it was all right to talk to. There was no set up place to go. There were no sort of formal acknowledgments for women who had abortions [and] needed counselling. There was nothing. (Reka)

Opting for Professional Support

In addition, the participants turned to health professionals for services and support at different stages of their experience. The feelings of the women studied are echoed in Christine's comment that "kindly support goes miles, . . . and a kindly hand and support . . . speak mountains." As the data show, professional support was the only feasible avenue for providing assistance in decision making and averting the consequences of enforced isolation for Ashley, Reka, Sinead, and Barbara. Amanda utilized professional counselling to broaden a support network that was already available to her. However, some women who opted for professional support were not always treated with kindness and understanding; some professionals' reactions were alienating and belittling.

For example, the physicians to whom Ashley turned for guidance (for decision making), and subsequently for an abortion, "were condescending and really belittling." One of the physicians admonished her not to become pregnant again rather than listening to her concerns about the side effects of the anti-contraceptive agents. This detrimental behavior from health-care providers was depicted in Ashley's narrative:

> He was asking me why I hadn't been on the birth control pill, and I explained to him that I had been at a previous time and that it just made me very nauseous, so I had been using other forms of birth control that hadn't worked, obviously. And he said, "As soon as this operation is over, I want you back in here, and you're going on the pill." He was totally not even listening to what I had said.

In contrast, representatives of the Planned Parenthood agency conveyed to Ashley "a totally different reception." They were "very supportive of" her and her approach to the decision-making process. The context of Ashley's need for pre-abortion counselling indicated one important implication for providing support. Supportive health-care providers should consider exploring the ways that women reach their decisions regarding abortion, rather than probing the reasons behind it.

Questions regarding readiness for the procedure were viewed by the women as appropriate: "'You sound secure with [your decision],' and I said, 'Yes, I would like to go ahead with it'" (Christine); "'[Are you] clear about what [you are] doing?' I was ready to say; 'Yes, I am. I know exactly what I'm doing'" (Catherine). In addition, a health professional could help a woman to differentiate between factors contributing to her decision and those causing equivocation: "[I] had already made my decision really, but I just felt very unsure; I felt like maybe I'm missing something, maybe I'm forgetting to consider something because this is the first time it's ever happened to me" (Ashley).

The importance of appropriate pre-abortion counselling was also accentuated strongly by Reka, who, regrettably, had no access to such services. Reka's great need for clarifying and channeling her feelings and for obtaining information about the potential post-abortion aftermath and resources for counselling were never met. Considering her terminated pregnancy as meaningful, as a "human being that was aborted," Reka had already carried a heavy burden. Yet the lack of emotional support prior to the abortion and the lack of counselling afterwards significantly increased the existing turmoil. The additional turmoil arising from either the lack of or deficient support is portrayed in Reka's citations:

> The other thing was that if at any time anyone in the system had said, "I want to sit down—"And no one actually talked to me about it, no one from the GP, no one ever discussed it. No one ever said to me, "Well, let's hold

> it a minute. Why don't you and your husband and I—" or "Why don't you and I sit down and talk about this and make sure this is what you really want to do?"
>
> Certainly no one even spoke about how you might feel afterwards. I was totally unprepared for just the horrendous emotional trauma I felt afterwards. No one had suggested that that would be there or how I would feel. No one talked about getting help. So it was aloneness, an incredibly alone experience.

The prospect of the active involvement of men together with women in pre-abortion counselling appeared to be another related dimension of emotional support. Depending on the stability of their relationships, women might desire to involve their partners in supportive counselling, as was epitomized by Reka and Olivia. Both Reka (in the quotation above) and Olivia ("So . . . we went in and we talked with them about it") brought their partners to their appointments with health professionals.

After the abortion, a number of women from this study reached out to health professionals to address the emotional impact of the experiences associated with the abortion. Some health professionals created a supportive atmosphere and responded to their concerns with compassion and understanding; however, others responded to them in a destructive manner. The debilitating behaviors of health professionals were portrayed by Ashley and Reka. Barbara, wounded from the effects of an illegal abortion and the lack of desired emotional support, was further injured by a professional during a follow-up. Consequently, those compounding psychological wounds caused Barbara to experience depression: "[The nurse] was very anti-abortion, so my follow-up visit with the whole thing was most uncomfortable and unpleasant and moralistically crappy. So the whole experience, I think, put me into a nose dive and pretty soon into depression."

Empathic listening was one of the most efficient tools for providing post-abortion supportive counselling. Unfortunately, some health professionals were unwilling to listen to the women's stories. Professionals who were distant from the women's experiences were unable to help them identify areas of conflict contributing to emotional pain. For example, Barbara attempted to put her experience into perspective by divulging her story to a health professional. However, the health-care provider disregarded the painful experiences associated with her abortion:

> Since I hadn't even told anyone about this abusive situation—this guy, that doctor—what a broken relationship, an absolutely terrible thing. So I'm telling her this, and instead of responding to the fact of my being injured and abused, I mean molested, . . . she had me convinced that I was alcoholic, that I was reacting to that. I mean, that was my life story, and she didn't even listen to the abusive thing. It was like she never heard anything that I was saying.

For Reka, lack of social support resulted in significantly exacerbating her depressive illness. She was loaded with "tremendous guilt" at this time:

> I felt quite helpless. Quite helpless. I felt a tremendous sort of religious guilt or moral guilt. The trauma was that there was no one, really, that it was all right to . . . talk to. There was no set-up place to go. There was no, there were no sort of formal acknowledgments for women who had abortions [that they] needed counselling.
>
> [Lack of support] really reinforces your sense that you have been a bad person, an evil person. I [felt] a lot . . . of superstitious fear that my children would be taken away from [me], [and] they would die, and there I would be without children.

It was at that point that Reka recognized her need for professional support because of her concern about her ability to care adequately for her children:

> [I] decided that I needed to talk to somebody professionally because I just felt that I was . . . unable to manage what I needed to, or give my children the attention and caring that they needed. So I . . . went to a psychiatrist.

However, her quest for help was unsuccessful: "He was incredibly busy. I was the last appointment of his day, and he used to fall asleep." With determination and persistence, Reka continued to explore more dedicated health professionals for desired support to enhance coping with "the guilt." With the supportive counselling provided by a health professional "who was a very, very passionate person," Reka reconstructed the meaning of her abortion. The new meaning in the resolution of her life-crisis situation helped her decrease the anguish and guilt and bolster her self-esteem and forgiveness. She developed strengths to successfully draw an end to the most painful aspects of her experience:

> When I worked through it with him, he helped me to grasp notions like, "You do the best you can at the time with what you have." Based on the situation, it was a wise decision or a reasonable decision, . . . and everything I felt decreased; but, I mean, it wasn't gone. So I think I

> certainly feel no guilt at this time, . . . which is different, that feeling no regret; I mean, the feeling of abandonment from my husband. But I think over a very long time, I think I began to understand that his inability was his own and had nothing to do with me.

Considering the prevalent social stigma attached to abortion, Amanda required professional help even though she was surrounded by strong support networks. Her supportive friends and family could not shield her from the social stigmatization. She was exposed to social disapproval that caused "a little bit of mental anguish." Therefore, she "did go through counselling" that helped her clarify her feelings and sort them out in a more manageable way: "The lady I went and saw was very good, made it very clear in my mind for me in a way that I could handle it" (Amanda).

According to the data, after the abortion, emotional backlash is usually experienced by women due to lack of appropriate social support compounded by social disapproval and social condemnation. Correspondingly, the women who were exposed to social judgment and who were lacking adequate social support had difficulty resolving their experiences. Paula and Catherine, who had support, acknowledged, however, that social judgment could have interfered with their healing:

> If I had someone that was condemning me or seeming to condemn me, that really would've done something to my head. I don't know whether I'd have gone through [with it]. (Paula)
>
> If the people had not been as kind to me, I think maybe emotionally I wouldn't have felt as at peace as I did. I think that the emotional support was very, very important. . . . The nonjudgmental aspect of that was very, very important to me. . . . Their kindly support was really important at allowing me perhaps to heal as quickly as I did. (Christine)

Health-care providers who created a supportive atmosphere helped the women deal with the whole range of feelings and issues associated with abortion. Respect, empathic listening, and acknowledgment of all depths and dimensions of the experiences associated with abortion constituted the essential aspects of the supportive atmosphere. The abortion procedure is "a very vulnerable time. . . . Some women may think that they are doing a wrong thing. They may feel very guilty" (Catherine). The women were vulnerable to verbal and unspoken judgment, yet they were also receptive to any aspect of caring. This was clearly expressed by Amanda and Catherine in the citations that follow:

> I was able to sit down and talk, and [a nurse] was so approachable. . . . [I] had somebody to sit there and talk to because I was by myself as well. It was very nice, it was so comforting to me, in a way that nobody will ever know, that I know that I wasn't by myself, that I wasn't doing this all alone, and this is something that I didn't have to deal with all by myself. There was somebody there to help me deal with it, which is a wonderful thing because it's a very hard thing for a woman when you are going in and you're getting something like that done.
>
> If [a woman] needs a hug, give [her] a hug. If [she] just needs . . . a back rub, give her a back rub. Some women don't like to be smothered. Other women need to be. Just be aware of their differences [and preferences]. . . . They need to be in control [as much] as possible. (Catherine)

To help women cope with their experiences of having an abortion, the health professionals "can't be taught," yet they need to have courage "to take a risk" because "you're stepping into somebody's personal space" (Sinead). Sinead elaborated:

> So for a nurse in an abortion clinic it feels to me like [she] needs to learn how to take a risk, and to say, "Are you all right? Do you need [help]? We can offer you help [if feel you need it]." Look you in the eye and say, "I see you are having an abortion. . . . How is that for you?"

Those who participated in this study are examples of risk takers acting on behalf of other women so they can better cope with similar experiences: "Maybe we're risk takers called upon to speak up and teach [professional] people to step out of themselves, and put yourself out a little bit" (Reka); "Probably nobody taught [nurses how to take a risk]. Probably they've been conditioned like the rest of us" (Sinead).

Three of the participants sought support from professionals outside the conventional health establishment. These women's encounters with professionals outside the medical field yield a more positive picture. For example, 20 years later Barbara, being "really frightened and very sad and filled with so much feeling," turned to "a psychic person" who helped her gain insight and understanding into her distress:

> I had a meeting with a psychic, a person who can see auras. He was asking me if I had ever been abused by anyone. My first thing was to think about it in childhood, and I said no, but all of a sudden I recalled that I was [abused] by this abortionist.

Sinead employed an "art therapist" to guide her through art work to gain an understanding about the underlying meaning of a "haunting" dream. By understanding the meaning of that dream, she acknowledged the need for dealing with the unresolved abortion: "She did some amazing stuff. She really coached me." For Sinead, coaching was a desired attribute of support that advanced her path to healing: "It was a most amazing experience to do this. It was just kind of a healing thing". In addition, Sinead also benefited from support from "an acquaintance" who helped her "set up a ritual" to promote her healing.

Amanda turned to a Catholic priest for support; he helped her cope better with fear of God's retaliation. "I thought that I was going to hell for [having an abortion]" and "[was] unforgivable in God's eyes." She explained the support that she received as follows:

> He made me feel comfortable enough. He told me no matter what I do in God's eyes, I will always be a perfect child, no matter what I do. Nothing I do is ever unforgivable to him. That made me feel a lot better. I felt a lot more at peace with myself and the fact that I could deal with it. . . . I still go and talk to him every once in a while, just for my piece of mind and my esteem, as it did get knocked down a bit with this.

Counselling might help women "value [their] experience [and] honor the [abortion] process" (Ashley). By referring to drama, art, and poetry and by using a metaphor for teaching or counselling, nurses can help women better understand the significance of their experiences. Literature evokes emotions that provokes reflections, leading to a better emotional and rational understanding of the experience. Such an understanding facilitates the healing process: "[There is] a better chance of healing when a story [triggers] emotional responses needed for review of old emotions" (Sinead); "[Metaphor] is so important in any teaching—to reframe, to observe and respect a process" (Ashley); "It's important as we women realize more and more the value of literature in our lives" (Sinead). It helps women discover a "role model. Modeling facilitates learning" (Sinead) of more effective coping strategies.

Based on the context of this study, social support encompassed rational or cognitive, emotional, and instrumental domains (Figure 5). Each domain comports a particular function and aims at a specific mode of support according to the needs of a woman. The rational domain focuses on problem solving and consists of an informational and a guidance-providing process. Support oriented toward problem solving helps women in the following areas: to facilitate and validate the decision-making process, to obtain information regarding the psychological aftermath, and to find counselling resources. Several women sought guidance to facilitate their grieving and healing processes.

The emotional domain consists of the interpersonal function of support aimed at nurturing and comforting (Figure 5). Adequate emotional support helped the women vent their feelings and emotions, validate their experiences, and bolster their self-esteem and confidence. Instrumental support includes assistance with transportation and accommodation. Partners, family, friends, and professionals were considered to be an important source of social support. Cognitive and emotional support could be provided simultaneously by all these resources.

To help the women cope effectively with the experiences associated with an abortion, an effective provider of support should respond to their operational coping level:

> "If [a woman] was asking for information on an emotional level, I would have to say [what she] may feel. . . . [If a woman was asking] information [on a rational level], I would . . . put them in touch with their reality. . . . It depends on what level they are asking [for help]."

To understand the level on which the woman is seeking help, a partner, a family member, or a health professional needs to "be very sensitive, listen to what [she] is telling you, [and] read between the lines" (Amanda) in order to provide appropriate support.

In relation to the decision-making process, a woman might need support on both rational and emotional levels. Support delivered on the rational level was appropriate when the women asked their partners to share responsibility in the decision-making process. On the same level, families, friends, and health professionals could help the women clarify and validate their decisions. The day before and the day of the abortion procedure, the women required support on the emotional level while experiencing mixed feelings regarding uncertainty arising from the impending abortion. The women whose partners responded to their needs "strictly theoretical[ly]" or used "intellectual arguments" to offer them help felt dissatisfied with their partners' support. Acting in such a manner, these partners created emotional distance, a false sense of freedom and autonomy in decision making, even though some of them might not have intended to do so.

Inadequate social support that was not aligned with the women's coping level produced in women negative feelings and emotions, decreased self-esteem, and social isolation (Figure 5). Conversely, adequate social support that met the women's coping level at a particular time resulted in comfort, greater confidence in decision making, and increased self-esteem. The same principles of providing adequate social support at both rational and emotional levels apply to post-abortion women who seek support to promote healing. On the rational level, the women sought guidance in enhancing their coping skills and discovering strategies to promote understanding of their experiences. Helping women validate the experiences associated with abortion, thereby transforming them into a health-enhancing perspective, requires a resource person to respond to their needs on both levels.

In addition to empowering, social support served as a buffering mechanism, protecting the women from the deleterious effects of stress arising from an unexpected pregnancy. As a result, those women who received support and validation for their decisions were healed emotionally much more quickly. For many women, social support was beneficial in combating the negative effects of social judgment and condemnation. Social support was perceived by the women as adequate when they felt valued, cared for, understood, and accepted.

CHAPTER 5

DISCUSSION

In this chapter, following the summary of the findings, four aspects of this study will be addressed. First, the findings of the study will be integrated with similar findings in related literature. Second, the propositional statements derived from the findings will be presented. Third, the implications of the findings for nursing will be outlined; and fourth, the strengths and limitations of the study will be discussed.

Summary

Although all of the participants in this study experienced abortion in unique ways, their experiences also contained many common elements: "It is amazing how different [the abortion experience] is for each one. Just like a new experience" (Sinead), yet "there's probably a lot of similar milestones, just like in pregnancy" (Olivia). By using the grounded theory method, similar milestones were identified and articulated in a conceptual model of coping with the abortion experience (Figure 1).

Unexpected pregnancy caused "turmoil" in the lives of the women. This turmoil caused disintegration in the participants' sense of wholeness, posing a great risk to their mental health. For the participants, the decision to abort resulted in "an immense struggle" with other significant issues such as maternal feelings, strong ambivalent feelings, emotions produced by the pregnant body, myths surrounding motherhood, and fear of exercising their own "power to deny life." Considering the hostile environment as a threat to their mental health, the women often descended into the underworld.

Whereas living in the underworld protected several women from further social condemnation, it did not allow them to express their grief openly and validate their losses. The wounded Self, surrounded by shame and guilt, found an outlet to express the pain in "haunting dreams," depression, or unhealthy habits. Despite this relapse into shame and guilt, considered a normal part of change, the women continued to strive to restore a sense of wholeness within themselves, utilizing their own resources to their fullest. The cycle of restoring wholeness, brought into motion by evolving empowerment, consisted of three stages: (a) surviving the struggle, (b) beginning the process of healing: the "power of love," and (c) becoming whole (Figure 1).

The stage "surviving the struggle" consists of the process of coping with decision making, approaching and enduring the abortion procedure, and normalizing their own lives. Once the participants endured the abortion procedure, the struggle to maintain the image of being intact and a "good woman" continued until they were able to deal with other issues associated with abortion. As the data analysis reveals, a majority of the women dealt with many personal and societal issues that negatively influenced their experiences. All participants considered the abortion as a loss. They followed different paths to address their losses. Upon acknowledging their losses, the participants entered the second stage, "beginning the process of healing: the 'power of love'" to validate their losses and heal their wounded feelings. In the final stage, "becoming whole," the participants searched for purpose in their abortions and the accompanying experiences.

In addition to self-enhancing mechanisms such as acceptance, compassion, love, understanding, and externalization of negative emotions, social support accounted for the essential source of empowerment. As an empowering factor, social support determined the ease with which the participants went through the various stages and phases in order to achieve closure of their abortion experiences. Coping with these experiences became the impetus for the women's ongoing personal growth. In addition to conceptual diagrams, this growth was represented in the metaphor, "Tending the Garden: Restoring Wholeness." This gardening metaphor captured the essence of the processes necessary to cope with the abortion experience.

This metaphor could also describe this process without sacrificing an objective standard for the presentation of research findings. At an intuitive level, the metaphor enables emotional connections between readers and objective research data. Furthermore, the metaphor opens the way for readers to create a visual image that can resonate with their own personal experiences on a more intimate level. Drawing on the metaphor of the garden as emblematic of the slow, complex process of restoring wholeness, the researcher could add depth and meaning to research content by remaining sensitive to processes that are cyclical in nature: "Gardening is a year-round process—the interaction with the ground, the water, and the sun. It doesn't just last the summer; it goes on and on, in different phases" (Catherine). The gardener's function is restoration.

Used by the researcher as a symbol of the garden, a mythological apple, rose, and tree represent death, healing, life-giving, and rebirth (Walker, 1998). All these sacred expressions that underline the essence of the abortion experience endow this experience with new significance "beyond the idea of choice." When merged into the symbol of a garden, a rose-apple tree itself represents the process of restoration: "A tree regenerates itself. It gives leaves and fruits which fall down and bring more trees, so there is harvest" (Catherine). After completion of each of the several cycles, the women experienced a sense of wholeness.

In this study, each unexpected pregnancy could be compared to a rose bush that sprouts at the wrong time, consequently producing intolerable stress for the participants. To transcend this disintegration and chaos, the women decided "to stop [the] growth in its process," leaving one life for restoring another. Instead of the metaphor of a fragile rose bush, the researcher might better compare the women's healing power to a more hardy plant, to their having nurtured a rose-apple tree, perhaps, in a garden of the stronger Self that could grow, blossom, and "create seeds for tomorrow's garden" (Catherine). As a gardener, a woman has "control over what is grown and planted" under given circumstances. Thus, gardening involves choices and decisions that are made upon a thorough assessment and evaluation of inner strengths, abilities, and external resources that are necessary to carry on the responsibility for the garden: "[Is the water nearby]? Do [I] have the strength to carry it a long distance? (Catherine). Guided by their rational truth and intuition, the women "just knew" that "it would be wrong" to bring a child into the world under circumstances surrounding their lives at the time.

Similar to gardeners, the women had the strength and "willingness to sacrifice for the good of the garden" (Sinead)—for the dignity and quality of their own lives and those of their existing children. However, uncertainty surrounding the implications of abortion and societal ideals emphasizing "motherhood as a gift" made it difficult to carry out the decision. Similar to gardeners who value the cycle of seasons, the women learned "to honor the cycle of life/death." They fostered the strength to carry out the decision by pruning desires, weeding ideas, and negotiating the Being's departure. During this process, however, the women sustained either "clean cuts, [or] ragged wounds . . . which [later became] infected very badly" (Catherine) in several women by the exposure to social judgment and self-reproach.

A nonsupportive, judgmental environment often encumbered expressions of grief over the losses associated with abortion. When kept underground, the unresolved feelings can become detrimental to health just as the roots of the rose-apple tree are poisonous. Transformed into healing, emotional pain can bring forth compassion, rebirth to a stronger self, and renewal of the Self. "Healing, [however], doesn't necessarily just last three months. . . . It is an ongoing [process]" (Catherine) that occurs over time and does not follow a linear pattern. Symbolically represented by branches, this process is facilitated by cathartic events that contribute to recovering unresolved feelings. Leaves promote growth just as increasing self-awareness facilitates closure of the experience. In the process of becoming whole, the women gather the harvest—the benefits of going through the abortion experience and getting on with their lives. They shared the crop with other women going through similar experiences, thus enhancing their own experience with new significance.

The coping strategies that were undertaken by the participants and their efforts in coping were adjusted according to their resources. All those influences within the environment, similar to good soil, sunshine, and water, can either optimize or constrain coping strategies. Those participants who were nourished and nurtured on the respect, sympathy, and trust of others became more confident during the "very stressful decision"-making process. They also healed faster than those who had little or no support. Good stewards of the garden learn from their social network and from experts, including professionals. They compare skills and knowledge with others, follow their instructions, or imitate their actions. Similar strategies were used by the women to promote closure of the experience.

With sadness, tears of compassion, and a sense of satisfaction, the participants spoke their "truths," hoping to help others make similar journeys less traumatic. These stories which offer deeper insight into the process of coping might help nurses better understand the reasons behind the women's "anguish" and "the long-term effects." Consequently, nurses will be in a position to challenge the prevailing myths surrounding abortion. One way of influencing the attitudes toward women having abortions is by exposing "a nation's voyeuristic relationship with death—obsession with violence/death on the television screen, but avoidance [of] real death issues. Another form of violence is expressed by forcing women to have children against their will" (Sinead).

Review of the Findings

Unexpected pregnancy precipitated one of the most challenging crises of the participants' lives. Resolution of this crisis involved a struggle for their own survival and for the survival of their existing children. Although the pregnancies were terminated, the struggle to protect themselves from the consequences of social judgment continued, leaving several women with limited opportunity for grieving and healing. Often overwhelmed with sadness and fear of the consequences of social exposure, the women often buried their unresolved experiences. Once the women established adequate support, they unlocked the experience and validated losses associated with their abortions. Armed with collective awareness, the women empowered themselves. By connecting themselves to successful role models, they developed self-acceptance and compassion for themselves and for others. Finally, closure of the abortion experience included endowing it with meaning, acknowledging successful meeting of established goals, and contributing to other women's well-being. These coping mechanisms will be discussed in relation to relevant literature under the following subheadings: (a) abortion: a means to survival, (b) the abortion choice: taking the measure of responsibility, (c) ambivalence: learning to accept the uncertainty, (d) maintaining self-control, (e) living with a secret, (f) locking the experience up, (g) healing power: working through grief, (h) empowering and affirming the self, (i) endowing the experience with meaning, and (j) social support: a milieu for successful coping.

Abortion: A Means to Survival

Abortion, like other issues that are highly charged with emotion and are morally and politically complex, often provokes controversy among various sectors of society. However, as Dworkin (1994) pointed out: "Sometimes people who disagree passionately with one another have no clear grasp of what they are disagreeing about, even when the dispute is violent and profound" (p. 30). Dworkin's insight about conflict in general also applies to the controversies surrounding abortion. The findings from this study might increase public understanding of the coping process with the abortion experience, including key issues such as surviving, healing, and becoming whole.

Both this study and a growing body of literature have demonstrated that an unexpected pregnancy might considerably compromise women's well-being (De Puy & Dovitch, 1997; Jaggar, 1994; MacDonnell, 1984; MacKinnon, 1994; Paris, 1992; Sherwin, 1995). Unexpected pregnancies jeopardize women's control over the quality of their lives and the lives of significant others—either children, partners, or both (De Puy & Dovitch, 1997; MacDonnell, 1984; Paris, 1992). For all participants, their unexpected pregnancy caused a radical disruption of their lives, as is reflected in Dworkin's (1994) statement:

> For many women, bearing unwanted children means the destruction of their own lives, because they are still children themselves, because they will no longer be able to work or study or live in ways important to them, or because they cannot support the children. (p. 103)

Two of the participants claimed that "abortion is a life-death decision." This feeling was also expressed by several of the 29 participants in Carol Gilligan's (1982) study describing abortion as a life-and-death decision made for psychological survival. The view that the abortion decision is made in light of psychological survival was also reflected in Ginette Paris' (1992) book, *The Sacrament of Abortion*: "The choice [to abort] may no longer be between life and death; it is more likely to be in terms of psychological survival" (p. 95). A similar view was echoed in McDonnell's (1984) assertion that abortion is a life-and-death dilemma precipitating one of the most challenging crisis of a woman's life. As derived from the data in this study, the participants employed a variety of strategies to the crisis arising from their unexpected pregnancies and their abortions.

The Abortion Choice: Taking a Measure of Responsibility

According to this study, a choice to abort contains a question of love and responsibility that Eva Pattis Zoja (1997) described as "a question of the attitude" (p. 77). The choice that is made in light of love and responsibility is more complex and personal. It is governed by a thorough assessment of one's current circumstances rather than by abstract principles (Gilligan, 1982; Zoja, 1997). When people are in crisis, they frequently use primary cognitive appraisal and secondary problem-solving coping to deal with stressful encounters (Lazarus & Folkman, 1984). One of the survival tactics involves assessing whether the environment is hostile or friendly (Marshall, 1993). By utilizing cognitive appraisal in these ways, the participants assessed what was at stake in their encounter with the unexpected pregnancy. For all of them, unexpected pregnancy constituted a threat to their survival and their well-being and jeopardized opportunities to pursue their goals and commitments. According to three authors (Long & Kahn, 1993; Marshall, 1993), women tend to adjust their coping strategies according to their circumstances and the impact of stressful encounters. This argument supports the women's right to make an informed decision to abort and the right to carry out the decision without the influence of others (MacKinnon, 1994; Paris, 1992; Petchesky, 1990).

To make an informed choice, the women in this study assessed and appraised the degree of stability of the relationship with their partners. That appraisal also included the partners' willingness to share the responsibilities of raising children they already had as well as the newborn. This strategy accounts for a problem-solving process including an evaluation of coping resources (Lazarus & Folkman, 1984; Long & Kahn, 1993; Marshall, 1993). Two of the women would have continued with their pregnancies if their partners had offered to share childbearing responsibilities. Once the women learned that their relationships were unstable and their partners refused to raise newborns, they appraised their own personal potentials and resources for becoming a parent.

They assumed the responsibility for making an informed choice to abort by planning, assessing, and appraising their internal and external resources. Willingness to assume the responsibility for making a choice that would prevent suffering of the mother and her child demonstrates the highest moral capacity and moral responsibility (Paris; 1992); Sherwin, 1995). When confronted by difficult moral decisions, women, unlike men, pay less attention to theoretical principles (Gilligan, 1982). Similarly, the women studied refuted abstract moral principles and formed their own moral principles within the context of their experiential knowledge in order to make the responsible decision to conclude the unexpected pregnancy. Considering Dworkin's (1994) argument, such a decision is predominantly grounded in positive concern about the intrinsic value of the quality of human life.

Each of the women took into consideration many aspects of her life, including responsibilities toward herself and others, while making a choice to abort. As a result, each of them expressed several reasons supporting their choices. Like those in Gilligan's (1982) study, the women in this study considered responsibility to themselves, to the child-to-be, and to others while contemplating the abortion. Similarly, the women in this study also weighed their responsibilities against their goals and commitments in order to make their lives more fulfilling: "So my first concern was [my education and] my career. I didn't want to be a burden on my family" (Bev); "I still had a year left of school and I could see the impact of having a child now" (Yolanda). These and other reasons for abortion (detailed in the next paragraph) have been frequently cited (De Puy & Dovitch, 1997; Gilligan, 1982; Jaggar; 1994; MacDonnell, 1984; MacKinnon, 1994; Petchesky, 1990; Sherwin, 1995).

The women participating in this study took into account their ability to care for a newborn when they decided to abort: "I could hardly look after myself let alone look after a baby" (Ashley). The majority of the participants objected to a life situation that could compromise the care of the newborn, causing them and their existing children to live in poverty or in unstable parental relationships. For example, Ashley "didn't want to be on Social Assistance and get in that rut." Similarly, Amanda "knew [she] would either be on welfare or . . . would be working like a dog and not getting the child the proper attention, care, and love it deserved."

The participants also assessed their own needs for personal growth and development. They perceived continuing with "education," "securing finances," and/or "establishing more stable relationships" as priorities for personal development and stability. They considered these factors necessary for enabling them to secure their sense of self-worth and to care for their children in the future. Like some of the participants in Gilligan's (1982) study, Bev and Amanda also believed that "it would be awful for the child[ren]" to bring them to a world in which they would be unwelcomed and unloved. Their concerns for the welfare of future children were reflected by Paris (1992): "Giving life is the fairest of gifts; it cannot be given halfway" (p. 61) without the ability to carry out responsibility for their well-being. As Bev said, being "forced to keep the child . . . would have been [unfair] because . . . of the [low] quality of life you can offer your child . . . from the fact that you don't want that child." Her reflections were also echoed in Paris' (1992) assertion:

> It is an unacceptable moral violation to force any woman to carry and raise a child against her will. It's a very serious matter to damage [the mother-child connection] right at the beginning of life because the seeds of bitterness are sown at a time when love and receptivity are called for. Forcing a child to live in a body that is hostile to it must be denounced as cruel. (p. 62)

Like some of the participants in Gilligan's study, Reka's decision to conclude the pregnancy was necessitated by an inability to manage additional responsibility alone: "Abortion wasn't a possibility that I wanted to take on, . . . but [having one more] child with no support from my [partner] . . . would aggravate my depression." For similar reasons, Olivia was quite devastated to learn "that an abortion was the choice." Both Reka and Olivia perceived the abortion as a necessary "sacrifice" for their sake and that of their existing children, as well as for the sake of children still to come. Sacrifice of the child-to-be that is made in terms of survival, love, and responsibility emphasizes the significance of the abortion decision (Paris, 1992; Zoja, 1997). For example, Paris contended: "Sometimes [abortion] is necessary to sacrifice the fetus to a higher cause, namely, the love of children and the refusal to see them suffer" (p. 107).

While acting from concern for quality of life for themselves and others, the majority of the women recognized motherhood as a myth. Despite this insight, several participants still found it stressful and difficult to put this myth aside when deciding whether or not to abort. Unattainable societal ideals emphasizing "motherhood as a gift" can complicate the decision-making process (De Puy & Dovitch, 1997; MacKinnon, 1994; Paris, 1992; Petchesky; 1990). The portrayal of women who contemplate abortions as "baby-killers" might result in considerable stress during the decision-making process (De Puy & Dovitch, 1997; Hutchison, 1997). As Zoja (1997) suggested, such stress can be decreased by accepting abortion as a symbolic form of killing:

> Consciously accepting the idea of killing . . . merits respect and a suspension of conventional judgements. Most of the women who are capable of holding such an attitude already feel that they cannot be touched by rigid and facile moral judgements. (p. 74)

Considering Zoja's (1997) argument, there is a need to go one step further and admit that abortion involves killing. In the context of this study, abortion involves three kinds of symbolic killing: (a) of the image of "the child" that might have suffered upon entering into an unwelcome world, (b) of a woman's internalized images that inhibit her potential growth and development, and (c) "of a poor relationship." Such a disembodied form of killing carries an expression of love, protection, and responsibility.

For all of the participants the choice to abort was a "very difficult decision," "a tough decision to accept." Several of them agonized after the decision had been made, even though they believed their choice was the best alternative. Dworkin (1994) argued that "the sometimes agonized process of decision is a process of judgment, not just choice, that it may go wrong, that one may be mistaken about what is really important in life" (p. 206).

Ambivalence: Learning to Accept the Uncertainty

For several women, enduring the ambivalent "yes/no, no/yes" feelings comprised one of "the most difficult moments" of the entire abortion experience. Estes (1995) asserted that a woman might experience ambivalent feelings because of her double-sided nature: her rational mind and her tender soul. A woman's body preparing for motherhood (Hutchison, 1997), her natural drive toward a relationship to the Other, and the cultural messages supporting motherhood run counter to her choice and pull her in two directions (De Puy & Dovitch, 1997; Griffiths, 1991; MacDonnell, 1984). Correspondingly, this study demonstrated that the "emotional level" which speaks of women's emotions and interrelatedness conflicted with the "intellectual level" which speaks of rationality and pragmatics. This inner conflict caused ambivalence in a majority of the participants. Often the act of abortion and its implications produced ambivalence rather than the choice to abort (De Puy & Dovitch, 1997; MacDonnell, 1984; Paris, 1992).

Uncertainty is a normal emotional response to a life-shaping decision. As Dworkin (1994) observed: "People are often deeply uncertain about which decision is right: we shift and change before we settle, if we ever do, into the comfort of firm conviction" (p. 205). For the participants, going through the uncertainty of acting out the decision and implications of abortion was a painful process. This uncertainty and pain is reflected in Estes' (1995) statement: "[The] feeling of being torn comes from hearing, consciously or unconsciously, something calling us, calling us back, something that we cannot say no to without hurting ourselves" (p. 300). It is also frightening to say "no" to motherhood, which has been glorified for millennia. No less difficult is saying "yes" to oneself, because this "yes" usually connotes selfishness (Paris, 1992; Zoja, 1997).

Similar feelings were experienced by several participants who coped with uncertainty up until the last moment before the abortion occurred. They reconciled their ambivalence by reexamining their own and outside voices, by accepting "the gray area," and by balancing their decisions against their circumstances. As with some of De Puy and Dovitch's (1997) informants, one woman in this study said good-bye to the myth of motherhood to reconcile her ambivalence. Although a bonding process between woman and fetus might be initiated in the early stage of pregnancy (MacDonnell, 1984), three of the participants ended emotional connection with their fetuses by creating a farewell dialogue with them before the abortion.

One participant intimated that it was difficult to endure the ambivalent feelings when alone in the procedure room. Based on data from this study, ambivalence occurring on an emotional level is a common and normal emotional response to abortion. Such ambivalence might provoke deeper reflections about death, life, motherhood, relatedness, and responsibility. These reflections engaged the women in conscious self-scrutiny, resulting in deeper insights about internalized cultural and religious values that called the rational decision to abort into question. Ambivalence might indicate the woman's need for empathic listening, caring, and support for her decision firmly based on a rational level.

Maintaining Self-Control

De Puy and Dovitch (1997) contend that women might desire to go through an abortion with minimal awareness and therefore request general anesthesia to achieve complete emotional shutdown. In this study, however the women were surprised by having their abortions performed under total anesthesia. Those three women who had an abortion without anesthesia, but were given a tranquilizer and provided with sensitive care by health professionals, recalled feelings of relief following the procedure. Conversely, those participants whose abortions were performed under general anesthesia but were attended by uncaring medical personnel recalled the abortion process as an upsetting experience. Encounters with insensitive and patronizing health-care providers, inappropriate treatment by medical personnel (Congleton & Calhoun, 1993), assembly-line preparation, and lack of emotional support during the procedure caused additional turmoil surrounding the procedure (De Puy & Dovitch, 1997; Paris, 1992). To cope with such traumatic approaches, three of the participants attained comfort by distancing themselves from the experience and by wishful thinking. Both distancing behavior and wishful thinking are the emotion-coping strategies that facilitate problem-solving (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986).

Another emotion-focused coping behavior, the self-control strategy (Folkman et al., 1986) or self-protective mechanism (De Puy & Dovitch, 1997) was employed by several of the women. An ability to maintain self-control and privacy is of paramount importance for women enduring the abortion procedure, yet their privacy is already compromised once they enter a clinic (De Puy & Dovitch, 1997). Those participants who were treated unkindly by health professionals or abortionists kept their discomfort to themselves, knowing that their needs for comfort would not be met. This helped them maintain a sense of control over the abortion process. Similarly, two of the participants who induced the abortion by themselves did not let others know their actions and the pain they experienced from going through the abortions. One conclusion of this study is that the meaning of abortion, like the meaning of miscarriage (Lee & Slade, 1996), can be influenced by the care provider. The inappropriate phrase "It is over" used by a nurse to a participant as she was emerging from anesthetic resulted in heightened feelings of guilt.

Living Life With a Secret

Even though the abortion is completed, the struggle with the experience is not; the surviving state continues. After the abortion, many of the women struggled with protecting themselves from hurtful insinuations of either family members, friends or society at large who strongly opposed abortion. The participants adjusted their coping strategies which allowed them to sustain and normalize their lives frequently in unfriendly environments. Marshall (1993) affirmed that women adjust their coping strategies depending on their circumstances and their situations. After perceiving the environment as unfriendly, a majority of the women studied concealed the abortion experience to protect themselves from negative influences of family, friends, or health professionals. Depending on the specific situation, revealing or concealing some aspect of self was viewed by Parse (1992) as a healthy human response.

A significant number of the participants were already subjected to negative attitudes and judgments from their families, friends, or health professionals while making their choice and during the abortion. De Puy and Dovitch (1997) contended that under such circumstances "[a woman] feels abandoned by the culture she lives in and fears the repercussions of sharing her personal story because it is so controversial" (p. 72). Consequently, women deliberately cope with their abortion experiences silently to avoid heightened shame and guilt even at the risk of increased social isolation (De Puy & Dovitch, 1997; Kesselman, 1990). Fearing further cultural disapproval and social stigmatization, two of the participants remained silent about their abortion experiences and coped alone without conscious awareness for over 20 years.

Being already harshly judged by significant others for considering an abortion, another participant isolated herself from them for "a couple of months." Despite her fear of disapproval, one of the women reached out to a family member for support. As a result, she was "shunned [by the] entire family." The other participants cautiously shared their experiences with chosen individuals even though they still experienced their judgments.

Remaining secretive about the abortion experience does not necessarily indicate women's low self-esteem or shame. They might, however, keep their abortions secret to protect their healthy self-esteem (De Puy & Dovitch, 1997). The majority of the participants experienced various magnitudes of shame and guilt. Both shame and guilt are considered to be socially based emotions (Adler et al., 1992; Robertson, 1994), which corresponds with Paris' (1992) assertion that "shame always expresses the value transmitted to us by our culture" (p. 103). Correspondingly, to explain the experiences of the participants, guilt can be defined as an anxiety and a fear of disapproval and punishment for violating a social standard of right and wrong (Cowles, 1996). The participants considered their abortions morally right in the context of their experiential and intuitive knowledge. Nevertheless, society's condemnation for violating its moral standards could force guilt on them (De Puy & Dovitch, 1997; Hutchison, 1997; Paris, 1992; Petchesky; 1990; Sherwin, 1995).

Keeping abortion secret because of the prevalent social antagonism toward abortion can be a burden that intensifies guilt and shame. (De Puy & Dovitch, 1997; Hutchison; 1997; Kesselman, 1990; Paris, 1992). Several of the participants experienced the paradox of keeping the abortion secret as a self-protective mechanism of solace that still resulted in shame and guilt. They corroborated that keeping a secret is likely to result in reinforcement of socially defined values of bad and wrong: "It's an agreement that you have something to be ashamed of if you're keeping secrets" (Reka). Keeping the abortion secret also causes other problems, such as the inability to validate the experience by sharing it with others and, consequently, the inability to accomplish closure (De Puy & Dovitch, 1997; Hutchison, 1997).

Locking the Experience Out

Zoja (1997) contended: "Its very protagonists—the women who have had an abortion—attempt to leave it behind them as quickly as possible, erasing all its traces and banning it from thought" (p. 6). Considering the lack of social recognition of the abortion as a loss (Congleton & Calhoun, 1993; De Puy & Dovitch, 1997; Kesselman; 1990; Lee & Slade, 1996; MacDonnell; 1984), several of the participants negated either the entire abortion experience or certain aspects of it to escape from intense emotions. Olivia "shut the whole experience out . . . the next day," and Paula "placed it somewhere else." Sinead had "never dealt with" the experience for over 20 years. Barbara separated herself from the experience by developing "a mental block . . . [while] running away from sadness." To move on with her life, Caroline refused to "dwell on the past." Alternatively, she was "pulling out the joys of each day." Christine was "looking into the future," and Catherine was "living in the moment." Similar mechanisms of suppressing or denying the painful aspects of their abortion experience were used by the participants in Kesselman's (1990) and Congleton and Calhoun's (1996) investigations. These strategies are considered emotion-focused (Folkman et al., 1986) that enhance problem-solving coping, thereby motivating the women to move forward with their lives.

However, unresolved experiences, including grieving, are likely to painfully affect the women's psychological well-being (De Puy & Dovitch, 1997; Kesselman, 1990; MacDonnell, 1984). The magnitude of the resulting emotional discomfort that was experienced by three of the participants is accurately reflected in Estes' (1995) comments: "When a woman keeps a shameful secret it is horrifying to see the enormous amounts of self-blame and self-torture she endures" (p. 411). The unresolved experiences often find an outlet in disguised form (De Puy & Dovitch, 1997; Estes, 1995). As well "shameful secrets cause a person to become haunted" (Estes, 1995, p. 411): "that's mentally anguishing because [secrets] will come up and haunt you in years to come" (Amanda). The distressing secrets and unresolved grief were manifested in the dreams of two study participants, who did not recognize the underlying meaning for many years.

Unresolved experiences including grief might also exhibit themselves in health-deteriorating habits (De Puy & Dovitch, 1997) and depression (McAll & Wilson, 1987; Stotland, 1991). Two of the women studied required treatment for depression because they held painful aspects of the experience at bay. Unresolved grief is a frequent emotional residue from both induced and spontaneous abortion (Lin & Lasker, 1996; McAll & Wilson, 1987). The grieving reactions to abortion might occur in the long-term aftermath (De Puy & Dovitch, 1997; Tentoni, 1995). Tentoni observed that academic women who undergo elective abortion experienced increased guilt and grief for four to six months following the procedure.

Healing Power: Working Through Grief

A growing body of literature has indicated that women who have had an abortion perceive the abortion as a loss that involves grief in the process of healing (Congleton & Calhoun, 1993; De Puy & Dovitch, 1997; Kesselman, 1990; MacDonnell, 1984; McAll & Wilson, 1987; Tentoni, 1995; Witzel & Chartier, 1989). For the women studied, abortion represented the loss of innocence, the relationship, part of the woman herself, or the potential child. MacDonnell (1984) contended that the expression of grief over the losses associated with abortion might resemble bereavement surrounding the death of a loved one. Cowles' (1996) findings, that grief associated with various losses is a highly individualized, dynamic, and pervasive experience, correspond with the grief process that was demonstrated by the women. In other words, each woman studied acknowledged her grief at a different time and expressed it in unique ways by employing different grief-resolution mechanisms. The findings from this study indicated that grief and healing are complex, cyclical, and ongoing processes that correlate with identified research literature (Cowles, 1996; De Puy & Dovitch, 1997; Lin & Lasker, 1996).

Four of the women studied initiated grieving before the abortion, similar to the anticipatory grieving noted by Posvac and Miller (1990). Whereas two of those women continued grieving, several others began to grieve either immediately following the abortion or weeks, months, or years later, unaware of their unresolved grief. Other life events causing either distress or increasing insights might evoke buried or forgotten feelings and emotions associated with the earlier abortion (Kesselman, 1990; Russo & Zierk, 1992). Accordingly, women might make idiosyncratic connections to their abortions (De Puy & Dovitch, 1997; Lemkau, 1988) and might recognize the underlying meaning of their experiences. They might also recognize the source of their painful emotions and begin to work through their experiences within a broader, more meaningful perspective (De Puy & Dovitch, 1997; Kesselman, 1990; Russo & Zierk, 1992).

This study demonstrated that confrontation with other difficult choices such as retirement, death of a family member, or other significant life events triggered wistful reflections that motivated working through unresolved feelings. Consistent with these findings, the research literature indicated that subsequent childbirth and learning about early fetal development might trigger unresolved grief and guilt (Congleton & Calhoun, 1993; De Puy & Dovitch, 1997). For two participants, subsequent childbirth resulted in achievement of a sense of closure of the abortion experience. Lin and Lasker (1996) arrived at a similar conclusion while investigating patterns of grief reactions in women experiencing spontaneous abortion, ectopic pregnancy, and neonatal death. However, learning about early child development evoked intense guilt in one of the participants in this study.

Successful resolution of grief associated with abortion involves validating and creating meaning out of the loss (De Puy & Dovitch, 1997; MacDonnell; 1984; Peppers, 1987-88; Tentoni, 1995; Witzel & Chartier, 1989). As Estes (1995) postulated, one way of creating meaning is through the invention of rituals: "Ritual is one of the ways in which humans put their lives in perspective" (p. 211). Similarly, Paris (1992) noted that a ritual, such as "[a ritual gathering]," performed to resolve abortion experiences, might help women develop compassion for themselves: "A ritual [gathering] that is well adapted to the circumstance can help [women] feel the love, the sadness, and the regret associated with an interruption of pregnancy" (p. 93). In this study three women validated and created positive meanings for their losses by inventing rituals. The ritual gatherings enhanced disclosure of painful feelings and emotions (De Puy & Dovitch; 1997; Paris, 1992). In this study one of the women participating in a ritual gathering discovered that she was not alone in feeling shame and guilt because of assimilating negative images from a society that doggedly opposes abortion. With this acknowledgment and mutual support, this participant was able to dispel myths that perpetuated her self-image. Such exoneration resulted in "an incredibly healing experience." Moreover, two participants reported that their healing also was promoted by honoring their losses during ritual gatherings.

There are no socially recognized burial ceremonies associated with either spontaneous or induced abortion. However, validation of the losses resulting from these two kinds of abortion might be important for some women. (De Puy & Dovitch, 1997; Lee & Slade, 1996; McAll & Wilson, 1987; Paris; 1992). The women "have to discover an interior voice which is able to address [the loss]" (Zoja, 1997, p. 141). Two of the women studied created symbolic representation of their losses by using objects meaningful to them; and after meditating over the objects, they buried both the objects and the losses.

Validation and consequently successful resolution of grief can also be achieved by a Gestalt dialogue involving the woman's saying farewell to the fetus to end the relationship (Buckles, 1982; De Puy & Dovitch; 1997; Paris, 1992; Tentoni, 1995). Before the abortion, three of the participants held dialogue with their fetuses to end their relationships with them. Grief resolution can also be accomplished by both granting and requesting forgiveness of the fetus, thus freeing the woman from feelings of guilt (De Puy & Dovitch, 1997; Joy, 1985). One of the participants in the study utilized this mechanism to free herself from guilt by honoring her loss. Validation of the loss by revisiting the abortion site (Tentoni, 1995) might also promote healing, though this strategy was not employed by the women studied. As Tentoni observed, revisiting the abortion site for reflection might result in acknowledging the loss and regaining a sense of oneself.

Other strategies leading to closure of the abortion experience might include creative endeavors such as art work and writing (De Puy & Dovitch, 1997; Paris, 1992). Correspondingly, two of the women involved in this study employed painting and writing to enhance healing by exploring and expressing their feelings and emotions. Visiting a cemetery and leaving roses on the family grave was another healing strategy that was utilized by one participant, and similarly observed by Tentoni (1995). Witnessing his client's healing experience during a visit to the cemetery provoked in Tentoni the following poignant reflection:

> As a man, I have never been in a situation requiring me to make such an emotionally difficult decision as these women had made nor of knowing that my own family might not support my decision. . . . Many of us, especially those who are men, will never really comprehend what it is like for a young woman to face the moral, ethical, and religious dilemma of terminating a pregnancy. (p. 37)

Other crucial components of successful grieving that facilitates the healing process involve understanding that the relinquished fetus represents normal loss and ending (De Puy & Dovitch, 1997). To reconcile this ending, the participants, like those in De Puy and Dovitch's study, often recalled and reaffirmed the reasons for their abortions. The findings from this study, corroborated by the research literature, indicate that once the stress from the unwanted pregnancy was resolved through abortion, personal growth was promoted, unlike the potentially life-threatening situation presented by undesired pregnancy (De Puy & Dovitch, 1997; MacDonnell, 1984; Paris, 1992).

Empowering and Affirming the Self

The abortion issue embraces both private and collective aspects (MacKinnon, 1994; Paris; 1992; Petchesky, 1990). By shifting their perceptions from private realms to more public and political domains, through choice, all the women recognized the social forces making their abortion experience difficult: "There are people who are dead set against abortion" (Amanda); "[They make] women's lives miserable" (Paula). With increased personal and collective awareness, the women developed greater confidence in themselves. Another way of asserting oneself is the ability to reframe despairing remarks into empowering attitudes: "If you have ever been called defiant, incorrigible, forward, cunning, insurgent, unruly, rebellious, you're on the right tract" (Estes, 1995, p. 212). With such an awareness and confidence in themselves, the women were able to transform their anger and resentment at society's unjust attitudes into their own constructive behavior. By making their painful feelings visible and their voices heard, the women cast off the shadows surrounding their abortion experience: "I'm not a total murderer or killer" (Amanda); "Who are they to decide how many children [I should have?]" (Bev); "They don't know what's right for me" (Caroline).

For all the women, taking responsibility for their choices allowed them to take control of their decisions by drawing on wisdom derived from their own experiences. As Rodwell (1995) contended, freedom to make choices is embodied in empowerment, the essential ingredient of health. Authority and accountability are other aspects that contribute to making good choices. All the women participating in this study claimed the right to act upon their choice in an unbiased and safe environment. Although five of the women obtained voluntary abortions, two of them felt that their lives were still "in the hands of others." They felt that they were given permission rather than authority, and one of them still felt the need to "be nice to [medical personnel]" to obtain an abortion.

Taking account of their abortions, the participants declared that they made the appropriate decision, benefiting their lives and the lives of others. For example, Reka and Amanda affirmed: "I don't feel any regrets" (Reka); "I'm happy with my choice. . . . I'm glad I made that choice, because otherwise I would be going through a court battle for custody" (Amanda). Bev contended that "it would be awful for the child after it is born . . . if I [had] been forced to [have] the child." Consequently, the child would suffer from the implications of such a situation. By gaining this awareness, the participants reaffirmed their choice as a reasonable and responsible alternative to an unexpected pregnancy. Nevertheless, women resorting to an abortion even for such reasons as failed contraception "are shunned and frowned [upon] by society" for refusing the patriarchal mandate of motherhood.

With acquired collective awareness, the women developed strength to challenge the myths surrounding motherhood. As a result, they refused to allow their minds to be plagued by shame and guilt for having an abortion. It is rather a society or culture that should feel shame and guilt for supporting an imbalance of power that causes many women and children to live in poverty (Paris, 1992); "A culture that requires harm to one's soul in order to follow the culture's proscriptions is a very sick culture" (Estes, 1995, p. 189) "that shapes ideas and feelings in order to steal women's [insights]" (p. 471).

For the participants, social comparison constituted another essential component of developing self-acceptance and affirmation. According to Taylor (1983), this self-enhancing strategy can be used either for validating or reconstructing one's self-image to promote self-acceptance and to increase self-esteem. "This dynamic self-acceptance and self-esteem are what begins to change attitudes in the culture" (Estes, 1995, p. 219). The participants compared themselves to other women who were coping with abortions as effectively as or more effectively than they were. As a result, the women developed deeper self-acceptance, empathy, and compassion for themselves and for other women dealing with similar experiences.

The therapeutic effect of social comparison was promoted by participating in a focus-group interview. For example, until Sinead compared herself with another woman, she thought she was "a jerk" or "a whore" because she was involved in an intimate relationship without planning to marry. As a result of this comparison, Sinead developed deeper compassion for herself. When she faced the wounded self-image with compassion, she refrained from punitive self-appraisal. Consequently, a change in self-concept is likely to result in a woman's personal growth (De Puy & Dovitch, 1997; Estes, 1995). During the focus-group interview, Reka and Ashley developed a sense of normalcy while learning from each other that they both experienced their abortions as a loss. Comparing herself to other women who made their decision to abort under a restrictive abortion policy, Yolanda felt empathy for them and became "more focused on how [abortion] affected [her] life."

The power of healing and growth-promotion is embedded in self-compassion and compassion for others (De Puy & Dovitch, 1997; Estes, 1995). In this study, when the participants compared themselves to other women, they developed a sense of mutual connectedness that resulted in care and compassion. For example, Olivia felt fortunate to be able to bear her abortion as a personal loss by comparing herself with a hypothetical woman losing a child at birth. She could therefore offer deeper compassion for women in circumstances similar to hers. Ashley observed that "it was very, very hard" for another woman to carry on the responsibilities associated with motherhood under similar circumstances. Such a comparison afforded Ashley and Amanda reconfirmation of their decisions.

Endowing the Experience with Meaning

Although the women sought abortion as a means for survival, they experienced it as an empowering and transcending event. Meaning in going through the experience underlines the significance of abortion. To find purpose in the abortion experience, the participants reviewed psychological meanings of their abortions and the losses associated with their experience. In addition to creating new meanings, they also recognized benefits from going through the abortion experience. According to Russo and Zierk (1992), people sequentially reconstruct and reinterpret past experiences in light of subsequent events. Both the reconstruction and the reinterpretation of past experiences result in positive reappraisal that facilitates healthy coping (Folkman et al., 1986). Developed from a focus on the benefits and personal growth resulting from the abortion, positive meanings facilitate the acceptance and closure of the experience (De Puy & Dovitch, 1997; Folkman et al., 1986; Russo & Zierk, 1992; Zoja, 1997).

Shifts in perceptions of meanings (De Puy & Dovitch, 1997; Folkman et al., 1986; Russo & Zierk, 1992) result in viewing abortion in a broader philosophical perspective. Sinead allowed herself to name the aborted fetus "the little ghost" and the abortion "the interruption of the natural process." Olivia perceived the abortion experience as her "entrance . . . into the fullness of motherhood." After they became mothers, the abortion experience brought for Ashley, Olivia, and Catherine a new meaning to their sense of loss: "It was a way of saying goodbye/hello." For three of the participants, the "abortion was a sacrifice" for affirmation of their own existence and for their own development. Zoja (1997) asserted:

> When . . . a woman dares to challenge the sovereign power of the maternal ideal and is willing to pay the price for doing so, giving up her foetus—and with it own maternity—in exchange for individual development, this is indeed a sacrifice. (p. 98)

For several others, the abortion "became part of me" (Amanda); "It made me who I am" (Reka); and "It's part of my history" (Caroline). Mechanisms by which individuals create positive meanings while focusing on personal growth have been defined as a *positive reappraisal* (Folkman & Lazarus, 1985) that correlates with problem-focus coping (Folkman et al., 1986). Recognizing favorable personal attributes that have already been developed by using problem-solving mechanisms through positive reappraisal is an emotion-focused means of coping (Folkman et al., 1986).

When recalling the reasons for their abortions and assessing changes in their lives, the women recognized that one benefit from the abortion experience was personal growth. Experiencing personal growth through coping with the abortion experience was also supported in the research literature (De Puy & Dovitch, 1997; McDonnell, 1984; Paris, 1992; Petchesky, 1990). For each participant the abortion experience had a profound influence on their personal growth. Many of the women, especially Reka and Ashley, recognized the strength that was necessary to make a difficult choice. "It was the way to affirm my inner strengths" (Ashley). Such an acknowledgment gave the women the motivation and energy to continue with positive alterations in their own lives and the lives of others. Olivia acquired "more ability . . . as a mother to say 'no' to [promote her child's well-being by setting healthy boundaries]." Saying no to benefit the child's well-being is the first parental responsibility, and the first maternal experience that can be learned while refusing unexpected motherhood (De Puy & Dovitch, 1997; McDonnell, 1984; Paris, 1992).

Both Yolanda and Paula also recognized that their abortions were significant events that contributed to the betterment of their lives. Yolanda received "the momentum" to complete her schooling, and Paula continued on with her education. Several of the women developed greater appreciation of their lives through establishing reciprocal relationship with others. For example, Amanda "learned [not to] be so easily trusting to a man to ever let him take that much control into your life." Paula learned "to take better care of [herself] sexually," and Sinead began to better understand her sexuality: "[I] became much more in tune with [my sexuality]." Reka learned to "accept other people in all kinds of other experiences just where they are, without any need for judgment." Three of the women attained greater understanding and sensitivity for other women going through the abortion experience from learning "how they can be made to feel so small" (Ashley).

Recognition of positive personal attributes that resulted from going through the experience gave the women the feeling of having reached "complet[ion]." A sense of wholeness deepened the acceptance of abortion as a learning and growth-promoting experience. A sense of self is also developed through the experience of sharing and relating to others (De Puy & Dovitch, 1997; McDonnell, 1984; Hutchison, 1997). All of the participants believed that they were "risk takers," willing to share their voices to benefit other women going through similar experiences. By "speaking [our] own truth," we can change societal attitudes toward women opting for an abortion. Another way of influencing positive changes in the attitudes of others, especially those who express physical and verbal violence toward women having an abortion, is by challenging "a nation's voyeuristic relationship with death—obsession with violence/death on the television screen, but avoidance of real death issues" (Sinead). Several participants have made significant contributions to other women's well-being while they were facing an unexpected pregnancy and coping with the abortion experience. Two participants expressed the desire to become volunteers at an abortion clinic. Correspondingly, several authors (De Puy & Dovitch, 1997; Estes, 1995; Hutchison, 1997) have already postulated that women need to help other women accelerate positive change in themselves and in the attitudes of others.

Social Support: A Milieu for Successful Coping

Seeking social support represents another form of coping (Folkman et al., 1986). Mounting evidence attests to the importance of social support in helping women minimize stress involved in the decision-making process and facilitating their post-abortion adjustment (Adler et al., 1990, 1992; De Puy & Dovitch, 1997; Hutchison, 1997; Kesselman, 1990; Major, Richards, Cooper, Cozzarelli, & Zubek, 1998; McDonnell, 1984; Russo & Zierk, 1992; Tentoni, 1995; Turell et al., 1990; Whitmore, 1995). Correspondingly, the majority of the participants perceived social support as a paramount component of successful coping with experiences associated with their abortions. Partners, family, friends, health professionals, and those from other disciplines were considered by the women as important sources of social support.

Supportive Partners

All the women in this study exercised the right to make their final decision to abort independently, even though five made the joint decision with their partners. The partners of four other women declined to become involved in the joint decision-making process. According to several authors (De Puy & Dovitch, 1997; MacDonnell, 1984; Zoja, 1997), women experience relief when their partners share the responsibilities for decision making. In this study five of the participants who were supported by their partners also experienced an increased sense of confidence in making an informed choice. In contrast, nonsupportive partners might aggravate the stress involved in the decision-making process (De Puy & Dovitch, 1997). As one of the participants stated, her stress in decision making considerably increased when she "had to push [her partner] hard enough" to express his stance clearly. Partners' emotional distance from the decision- making process can be interpreted by the women as disavowal of responsibility, causing a sense of betrayal and resentment (De Puy & Dovitch, 1997; McDonnell, 1984). Several of the participants experienced similar feelings that arose either from withdrawal of the partners from decision making or their inadequate support.

The coping process involves both cognitive and emotion-focused mechanisms (Folkman et al., 1986). Women usually cope by combining these two modes (Marshall, 1994). To respond to their coping needs, supportive partners need to determine whether women are asking for support to soothe their emotions or to facilitate their problem-solving skills. Olivia, whose partner responded to her emotions by using "intellectual arguments," perceived his effort to comfort her as "useless at that particular point." Similarly, Reka's partner also responded to her emotional needs "strictly theoretical[ly]." By acting in such a manner, the partners created emotional distance which produced resentment and a sense of abandonment in the women. Not knowing how to respond to women's emotional needs, men frequently suppress their feelings by intellectualizing the abortion process (De Puy & Dovitch, 1997; Zoja, 1997). Joint pre- and post-abortion counselling might increase men's understanding of women's experience and their emotional needs. Therefore, men can help women cope more constructively (MacDonnell, 1984).

Genuine support and validation of the abortion experience by their partners was essential for many of the women. To soothe women's painful feelings, men need to acknowledge their partners' efforts in decision making and empathize with them through the abortion experience (De Puy & Dovitch, 1997; Griffiths, 1991; Paris, 1992). Women who have nonsupportive partners might experience negative responses to abortion and cope less effectively during the post-abortion adjustment (De Puy & Dovitch, 1997; Major, Cozzarelli, & Testa, 1992).

Upholding Family and Friends

Within the context of coping with their abortions, women tend to be selective in the social support that they seek (Major et al., 1998). Seven of the 12 women reached out for support from their families. Sinead did not seek support from her family because she knew that her "family didn't know what to do with [her] anyway." Bev avoided turning to her family for support while making her decision because she "didn't want to hurt her [family's] feelings." Knowing that their mothers were "anti-abortion," Reka and Caroline avoided asking them for support. Sometimes reaching out for support to family members can result in condemnation (De Puy & Dovitch, 1997). Ashley's mother accused her of "murdering her grandchild" despite having assisted another woman through an abortion. After her abortion, Reka was perceived as "totally evil" and was shunned for a while by her husband's family.

De Puy and Dovitch (1997) observed that a lack of support from family might have a negative impact on the women's ability to cope with the experience. This lack of support might result in a heightened sense of social isolation and alienation. Conversely, women provided with a high degree of support from family are less vulnerable and cope better with the social stigma (De Puy & Dovitch, 1997). These observations are consistent with the findings obtained from this study. In response to her mother's condemning judgment, Ashley "just really was isolated . . . and angry." Reka experienced a sense "of being left totally alone in the world," having no one telling her that she "was still a good person." Yolanda "had the support from [her] parents" during the entire process of the experience. As a result of adequate support from their families, both Yolanda and Bev "healed fast . . . physically [and] emotionally" without the need for professional counseling. Although Amanda's choice was "backed . . . up a hundred percent" by her family, she experienced full support only after visiting with her parents.

Supportive families essentially contributed to the women's well-being by enabling them to sustain their self-esteem, develop greater confidence in decision making, and validate their abortion experience. Acting as buffering agents, supportive families played important roles in protecting the women from the implications of the social stigma. When their partners and families were unavailable, unwilling, or unable to provide adequate support, the women sought support from their friends to help them cope successfully with the abortion experience.

Prior to abortion, supportive friends had a positive impact on enhancing the decision-making process. For instance, Paula "was surrounded by people who thought that [abortion was] the only way" of resolving the crisis surrounding her unexpected pregnancy. Similarly, Olivia's friends "trusted [her] to come to the right decision." As expressed by Olivia and Paula, "[trust, space], and respect" conveyed by their friends resulted in increased self-esteem and a sense of competence in decision making. Following the abortion, several of the women benefited from their friends' support, which helped them ventilate their feelings and channel their emotions. Friends who used humor and distraction to engage the women in pleasurable activities also fostered their well-being. One conclusion from this study that should also be noted is that women having an abortion are especially sensitive to social judgment and are receptive to the support of friends. This conclusion was further supported in De Puy and Dovitch's (1997) observations. Although 11 of the 12 participants were supported, to some extent, by their friends, only 3 of them perceived this support as nonjudgmental.

Supportive Counseling

This study also found a significant link between supportive counselling and successful coping with the abortion experience. According to this study, women might seek supportive counselling for a variety of reasons. Women might need to clarify and to validate the decision-making process and the feelings that develop around this decision (De Puy & Dovitch, 1997) without questioning reasons for the abortion (Paris, 1992). Although a majority of women employed a variety of self-directed strategies to validate their decision, six of them sought such validation from health professionals. Five of them who had abortions more recently were helped through the decision-making process, ambivalence, and anxiety surrounding the abortion by these professionals. Although for another participant clarification of her feelings and validation of her decision by a health professional was important, she was not given the opportunity to do so.

Supportive counselling that focuses on clarification and validation of the decision might enhance women's confidence and sense of competence in making the right decision (De Puy & Dovitch; 1997; Hutchison, 1997; McDonnell, 1984; Turell et al., 1990; Whitmore, 1995). Therefore, it also might decrease the stress involved in the process of decision making. Although Ashley "had already made [her decision]," she thought, however, "Maybe I'm missing something; maybe I'm forgetting to consider something." For this reason, she reached out to a health professional for support to help her clarify the decision-making process and to validate her decision. As several authors suggested, pre-abortion counseling might help women access coping resources and provide them with information about the procedure as well as the psychological aftermath (De Puy & Dovitch, 1997; Hutchison, 1997; Whitmore, 1995). For Reka, despite her need, such support was unavailable: "[No] one even spoke about how you may feel afterwards. . . . No one talked about getting help. So it was aloneness, an incredibly alone experience." Supportive post-abortion counseling might help women clarify the meaning of the experience and explore alternative ways of effective coping (De Puy & Dovitch, 1997; Turell et al., 1990). With professional support, Reka acknowledged that her abortion was "the best [she could do] at the time" considering her circumstances. Her guilt diminished as a result of increased self-worth. Professional support might also help women explore the factors that could contribute to psychological distress and enhance coping skills with negative reactions (Russo & Zierk, 1992; Whitmore, 1995). Through counseling, Amanda, who experienced "a little bit of mental anguish" from exposure to social stigma, became "very clear" about the ways for coping with social judgment. Barbara, who had periodically felt "really frightened and very sad" for over 20 years, turned to "a psychic person" to help her understand her distress.

There is consensus that supportive counseling should include grief therapy to help women enhance expression of their mourning and facilitate an appropriate grieving process (De Puy & Dovitch, 1997; Kesselman, 1990; McDonnell, 1984; Tentoni, 1995; Whitmore, 1995). Once Sinead acknowledged her need for dealing with the unresolved losses associated with her abortions, she turned to an "art therapist" who coached her through the grieving process: "It was a most amazing experience to do this, . . . a healing thing." Another professional helped her "set up a ritual" to promote her healing from the experience of having two abortions.

Propositional Statements

The following propositional statements were derived from this study:

1. Coping with the abortion experience is demanding and complex. It consists of several processes, such as making the decision, preparing for the abortion, closing the experience with grieving, and healing.

2. Three crucial factors that might determine closure of the abortion experience include ways in which the decision was reached, personal significance of pregnancy and abortion, and perceived social support.

3. Some women might perceive abortion as the sacrifice of motherhood and/or the child-to-be in exchange for personal growth. "Taking a life," a sacrifice that is enacted out of a concern for quality of life, represents the feminine values of caring and protecting. Such an understanding gives rise to moral aspects of abortion beyond simplistic moral principles, and even beyond "the idea of choice."

4. Aside from the personal significance of pregnancy and abortion, the process of coping with the abortion experience is complicated by polarized social, cultural, and political attitudes toward abortion. Acceptance of abortion as both an important health issue and a significant life event constitutes one precondition of successful coping. Because coping with an abortion is both personal and collective, such an acceptance also needs to be conveyed socially.

5. As a milieu for effective coping, strong social support protects women from the negative effects of social judgment that reduces abortion to an immoral act. Negative responses that might impede coping are often derived from the judgmental reactions of others and from a lack of social support.

6. As an important life event, abortion has notable implications for a woman's health. It reduces stress from unwanted pregnancy and cuts the risk to mental health and survival. Making such a difficult decision results in increased awareness of needs and potentials for personal growth and development. Reflections upon related concepts such as "the cycle of life/death," motherhood, relationships, responsibility, and women's sexuality help stimulate personal growth. This process is advanced by coping constructively with the ramifications of the abortion.

7. Women use cognitive and emotive mechanisms to cope effectively with the abortion experience. They adjust their coping strategies to confront the problem they face, drawing on inner resources, emotional strengths, social climate, and available social support.

8. It is crucial to acknowledge that many women might experience mixed feelings up to the last moment about acting upon the abortion decision despite rational affirmation in their choice. Voluntary pre- and post-abortion supportive counselling is essential in helping women cope with experiences associated with an abortion.

9. Abortion is associated with loss. Each woman might experience loss as more or less intensely associated with changed relationships, the relinquished fetus, or the declined state of motherhood. Often women will experience several losses at one time.

10. To bring about closure to the abortion experience, women need to validate the losses associated with abortion. Grieving is a cyclical process. Cathartic events, including major life changes, other significant losses, and reproductive health concerns might instigate grieving or renew a grieving process already begun.

Implications

The findings from this study derived from the women's different yet fundamentally similar stories have a number of implications for nursing. Knowledge derived from this study offers deeper insights into the phenomenon of coping in the context of social interaction and the personal significance of abortion. This insight might help nurses broaden their understanding of the moral and ethical aspects of abortion. The findings from this study explain why abortion is viewed as a significant health issue. The findings strengthen the link between the crisis and unexpected pregnancy as well as the link between abortion and personal growth. Equally important, the findings link abortion with other significant health concerns of women, including sexuality, family planning, fertility control, motherhood, and their sociopolitical and economic positions.

As such, the findings from this study have major implications for nursing education in the following areas: (a) the education of students undertaking basic registered nursing education; (b) the education of nurses who choose to deliver care for women dealing with unexpected pregnancies or contemplating and undergoing abortions; (c) the education of nurses planning to practice in the field of reproductive health of women such as family planning, fertility control, and sexuality; and (d) the education of nurses who deliver care for women seeking help through health crisis centers, shelters, and mental health agencies.

These implications are directed to four areas: (a) nursing education, (b) nursing administration, (c) nursing practice, and (d) nursing research.

Nursing Education

Education for nursing students. Because abortion is a frequent medical/surgical procedure (Gottlieb, 1995; Lethbridge, 1995), nurses working in all areas of practice will encounter women who have had abortions who might need help to achieve closure to their experience. Considering the high prevalence of abortion and its relevance to other women's health issues, it would be insightful to address abortion adequately in basic nursing curricula. Nursing students need to be offered the opportunity for a liberal education to attain a broad perspective on this critical issue.

The acquisition of a broad spectrum of knowledge will help new graduates develop better understanding of women opting for abortions in addition to developing respect for their decisions. It is essential that new nursing graduates be prepared to assist women in making informed choices and in helping them cope with the abortion experience in a health-promoting manner. This would include knowledge of the ethics of nurturance and relationships (Bergum, 1994), skills in communication, client education, supportive crisis intervention, and grief counselling. Related to counselling is psychological and mental health assessment that involves skills in listening, observing, and interviewing. Women seeking an abortion or going through the abortion experience might have difficulty expressing their feelings, or they might hide them to avoid judgment. Acquiring skills in attentive listening, keen observation, and appropriate interviewing might help students adequately assess psychological needs of their future clients. Because abortion revolves around a broad spectrum of women's sexuality, fertility control, and mental health, it is essential that nursing students acquire adequate knowledge in these areas. Considering that abortion is one of women's health concerns, it would be useful to incorporate women's health issues in undergraduate core curricula.

Abortion is also related to other issues that involve moral dilemmas, such as euthanasia and assisted suicide (Dworkin, 1994). Nursing students might find it difficult to understand these dilemmas by using traditional textbooks alone (Begley, 1995). Literature and drama might help nursing students and nurses develop a deeper understanding of human moral predicaments (Begley, 1995; Lanza, 1996). Because literature helps the audience enter into the experience of others, nursing students might gain increased insight into the meaning of such an experience for others. Through insight, nursing students can develop respect and compassion for others going through difficult experiences, including abortion (Begley, 1995; Lanza, 1996). It is therefore essential to help nursing students attain a better understanding of coping with the abortion experience by using drama, poetry, and autobiography.

Education for nurses. Nursing education about coping with the abortion experience, especially for nurses practicing in the field of women's reproductive health and abortion care, is critical. Traditionally, nursing is a woman's profession. As pointed out by the women studied, the problems that nurses personally might face are therefore similar to those experienced by women at large. These problems reflect societal values and biases that are framed by socialization, sexism, and stereotyping. Not surprisingly, some nurses might hold reservations about women undergoing abortions and might be unwilling to care for them. According to the findings of this study, some of the nurses that deliver abortion care tend to introduce their own biases and judgments into their practice. Nurses need "to take a risk" by reflecting upon the source and construction of their values. They also need to open themselves up to learning from other women's perspectives and thus develop deeper insights into the moral and social aspects of abortion: "Maybe we're risk takers called upon to speak up and teach [nurses] to step out of themselves and put themselves out a little bit" (Reka); "Probably nobody taught [nurses how to take a risk]. Probably they've been conditioned like the rest of us" (Sinead).

To ensure a sound knowledge base and quality of care according to the standards of nursing practice, it is recommended that nurses receive formal education during their orientation to an abortion clinic. This orientation would include the following aspects: a review of anatomy and physiology of the reproductive system, fertility control and contraception, pre/post-abortion care, interviewing and counselling skills, and psychological/mental health assessment. To maintain high standards of nursing practice, nurses need to continue their education by attending seminars and inservices related to abortion care and by self-study activities such as reading current, relevant professional literature. Feedback from a colleague might be another valuable educational avenue, especially while dealing with sensitive issues and vulnerable clients. Considering that abortion is highly relevant to sexuality, in addition to possessing a sound knowledge in this area, nurses also need to feel comfortable with their own sexuality. As a consequence, they will provide their clients with expert care that is informed, sensitive, unbiased, and nonjudgmental.

The participants in this study experienced several different losses associated with abortion. To work through the losses and to achieve closure on the abortion experience, the participants went through a grieving process. Several sought help to facilitate this process. For this reason, in order to provide expert care to their clients, nurses need to be knowledgeable about various concepts of loss and grief. In addition, nurses need to be able to use techniques that can facilitate the grieving and healing process. Finally, nurses need to acquire knowledge about the concept of coping that is specific to women. Nurses therefore need to possess a broad spectrum of knowledge to address the complexity of experiences associated with abortion and the complexity of coping with such experience. This suggests a need for the role of a clinical nurse specialized in abortion care. In addition to offering inservices related to abortion, the specialized clinical nurse could provide orientation and facilitate education of the nurses currently delivering and planning to deliver abortion care.

All nurses, regardless of their specialty, might benefit from attending conferences and seminars conducted by women that address health concerns related to abortion and reproductive and sexual health of women. The acquisition of such knowledge helps nurses gain insights into their own health agendas and into the myths surrounding women's health issues. Educated and insightful nurses will care for their clients with respect, sensitivity, and compassion. Also, they can end the stigmatization of women who have had an abortion.

Nursing Administration

It is critical that women confronted with an unexpected pregnancy have the right to choose their own option, including abortion. Equally critical is access to affordable, competent, and safe abortion care. Nurses can become vocal advocates for improving abortion care and the reproductive rights of women in the following ways: (a) by integrating abortion care into the health-care system, (b) by expanding nursing roles in reproductive health care, and (c) by providing anticipatory education.

Abortion care is related to other aspects of women's health such as unexpected pregnancy, family planning, fertility control, contraception, and sexuality. Considering that abortion is an essential aspect of women's reproductive health (McKee & Adams, 1994), it is important to integrate reproductive health along with abortion into the mainstream of health care for women (Gottlieb, 1995). Integration of abortion care with other domains of reproductive health in the health-care system might benefit women for several reasons. This integration might decrease the possibility for harassment and violent threats to women opting for abortions and to health professionals providing that care (Gottlieb, 1995; McKee & Adams, 1994). By locating abortion care along a continuum of women's reproductive health, nursing administration will attest to the significance of abortion as a health issue. Integration of abortion into the reproductive health services will provide women with the opportunity for comprehensive rather than compartmentalized care (Gottlieb, 1995, McKee & Adams, 1994).

With recognition of abortion as an integral aspect of women's reproductive health, nurses delivering abortion care might find such care a more rewarding field of practice. Leaving abortion separate from the mainstream of women's health, abortion care will remain an unrewarding field of nursing practice (Zoja, 1997). Nurses who provide abortion care will experience isolation, peer pressure, and harassment, in addition to lack of professional rewards (McKee & Adams, 1994; Zoja, 1997). For women opting for abortion, such an integration might increase their sense of privacy and prevent them from receiving assembly-line abortion care (McKee & Adams, 1994).

The nursing profession can play an important role in incorporating abortion care into the health-care system. By taking a leadership role, nurses can influence public policy regarding the provision of abortion services. This role can be carried out by educating policy makers about the importance of legal, safe, and accessible abortion services and by lobbying for increased financial coverage of the services. In cooperation with the Women's Legal and Educational Action Fund (LEAF), an organization that raises core issues of equality rights for women (Razack, 1991), the nursing profession can support initiatives to empower women to access abortion services as health resources and to incorporate them into a health-care system. (Gottlieb, 1995). The nursing profession can challenge the myths surrounding abortion by presenting facts regarding the risk of women's health from clandestine abortions versus positive health outcomes from obtaining safe abortions. The nursing profession can also call into question the myths associated with motherhood while being vocal about inadequate child support, an inadequate daycare system, and unequal socioeconomic opportunities for women.

Nursing, a female-centered profession, is in a unique position to assist women in taking care of their health. Nurses can address contraception, unexpected pregnancy, and abortion within the context of women's experience and circumstances surrounding their lives, including socioeconomic situations. To improve accessibility to abortion services and family planning, fertility control, and infertility care, nursing administrators can lobby for expansion and appropriate location of these services. This expansion can be achieved by structuring community health centers for women. A women's community health center could integrate reproductive health, mental health, and a variety of self-support groups along with counselling services. Such a configuration of women's health services would also allow nurses to separate reproductive health, including abortion, from the medical model.

Integration of women's health-care services can also facilitate team work among different health-care specialists, thus increasing the quality of care and client satisfaction. Expansion of abortion facilities requires an increase in the number of abortion care providers. As McKee and Adams (1994) postulated, nurses and nurse-midwives who focus on psychological aspects and preventive care might contribute to improvement and humanization of abortion care. As emphasized by McKee and Adams (1994), as well as the participants, abortion care beyond the purview of the surgical procedure is so critical.

Nurses are in an excellent position to extend nursing into another area of advanced practice by expanding it into vacant areas of health-care delivery (McKee & Adams, 1994). Such expansion might include prescribing oral contraceptives and counselling, prescribing and managing medical abortion (Lethbridge, 1995), and performing first-trimester abortion (McKee & Adams, 1994; Rosenfield, 1994). Nurses and nurse-midwives might wish to entertain such an expanded role after obtaining (a) pertinent training, (b) prescriptive authority for methotrexate and mifepristone (RU 486), and (c) prescriptive authority for oral contraceptives. Professional associations, such as the Alberta Association of Registered Nurses and the Canadian Nurses Association, could support this expanded role by including independent practice in the scope of the role of the registered nurse. Correspondingly, professional associations would be required to address the issues of accountability, accreditation, and reimbursement to ensure professional standards of practice of nurse practitioners.

Anticipatory education for women might constitute another expanded scope of nursing practice. When providing anticipatory education, nurses can address a variety of issues related to abortion that might involve publishing health articles for women and producing educational radio and television programs. By publishing women's health articles in lay magazines or by speaking on the radio and on television programs, nurses can educate women about the full range of options to resolve an unexpected pregnancy. While supporting the women's right to choose their own option, nurses, in particular, can provide education about the decision-making process and how to cope with the abortion experience in general.

To ensure adequate emotional support for women before, during, and immediately after the procedure, nursing administrators might consider involving female volunteers in supporting unaccompanied women. A concern for providing adequate emotional support for women on the day of abortion was expressed by a majority of the participants. Two of the participants suggested that volunteers at the abortion clinic can become valuable resources of emotional support for women.

Clinical Nursing Practice

Because social support emerged as a major aspect of caring for women coping with the abortion experience, nurses have a unique opportunity to respond accordingly. The findings of this study offer nurses practical suggestions for supporting women before, during, and after an abortion. On the emotional level, adequate support gives women a sense of being accepted, comforted, respected, and understood. On the rational level, such support results in enhancing women's problem-solving and solution-finding ability, increasing their insight, and developing more effective coping mechanisms. When strengthened by appropriate emotional and cognitive support, women are able to transfer potentially painful experiences surrounding abortion into growth-promoting events. Adequately supported women recognize and accept abortion as a significant life event that involves losses and gains. This recognition precipitates grieving that leads to healing and consequently celebration of the abortion as an empowering event.

Creating a therapeutic environment. Nurses might meet with women seeking support in helping them cope with various challenges surrounding the decision-making process, the abortion procedure, and the closure of the experience. Although each stage of the abortion experience might require different approaches, skills, and knowledge, a therapeutic environment provides common ground for supportive interaction between nurses and women. Such an environment includes physical setting, atmosphere, and attitudes of health-care providers. Supportive physical settings should be neutrally decorated to minimize potential symbolic expression of ideological perspectives and personal values. Nurses, in particular, play a key role in creating a therapeutic environment that conveys empathy, respect, sensitivity, trust, and understanding. This environment promotes growth-fostering interaction between the woman and the nurse, which might result in mutual empowerment that enables both the nurse and the woman to act effectively in the world. To be able to act in the best interest of women, nurses might need to consider revising their own values and beliefs regarding abortion. Because abortion was considered symbolically associated with death, nurses need to feel comfortable with issues related to death. With conscious effort, nurses need to put their values and beliefs aside in order to provide women with unbiased, nonjudgmental, and sensitive care. One canon of sensitive care is "supporting [women] in whatever decision they make." Another ingredient of sensitive care is fostering self-worth. Nurses need to be alert to their "unspoken judgment" that might reinforce a woman's perception of being "a terrible person." They need to convey to women the reassurance that they are still worthwhile individuals even though they choose to abort.

Nurses need to perceive abortion as a significant health issue beyond the medical perspective. If nurses viewed abortion from the women's perspective, they would respect each woman's individual perception of abortion. Depending on her values and her contextual knowledge, each woman might experience abortion differently. Nurses need to be open to women's symbolic interpretations of pregnancy and abortion. Some women opt for abortion even though this decision is at odds with their concrete moral principles. Their experiential knowledge, however, gives rise to a greater moral consciousness (Gilligan, 1982). This consciousness allows some women to choose abortion despite their previous values and beliefs. Correspondingly, a greater moral consciousness allows women to accept "death" and killing the image of a potential child who might have suffered after entering into an unwelcome world. It also allows giving up motherhood for a greater value at the time—personal growth and development to become a better parent in the future. This consciousness allows giving up pregnancy, the symbol of the ability to create, in exchange for creating positive changes within and around oneself.

By entering the women's contextual knowledge, nurses can attain a deeper understanding of women's struggle with challenges surrounding the abortion experience. To gain access into such knowledge, nurses need to be respectful, "humane, approachable" and objective, but "not painfully distant." They should be "truly present" for women seeking support. Their presence would be indicated by attentive "listen[ing]" and "read[ing] between the lines" of the expression of concerns and feelings. To obtain a clearer picture of women's experiences and their needs for support, nurses should simultaneously listen attentively and "observe their body language" for nonverbal expressions. Importantly, nurses' genuine presence will be demonstrated by providing support according to women's needs and their operational coping level.

Empathic listening will encourage honest communication between nurses and women. This communication should be facilitated by using women's own vocabulary rather than clinical terminology. For example, by using the term "baby" as a pregnant woman would, rather than "fetus," the nurse signals that the losses and grief accompanying abortion are normal. In this supportive environment, women can openly address their concern regarding the disposal of the aborted fetus. Prior to explaining the clinic's policy, nurses might explore women's ideas and wishes regarding the care of the relinquished fetus. If appropriate, they might consider women's preferences for handling the aborted product of conception. During the procedure, one participant was comforted by "the image of the woman coming with the [lovely] basket to take the child." As observed by the researcher, another woman (not participating in this study) cried after the abortion: "Where is my kid? What has happened to my kid? I want to see my baby." Concern about the disposal of an aborted fetus was expressed by the women participating in the focus-group interview. Women should be allowed to take the aborted fetus home, should they wish to do so. A burial ceremony for the relinquished fetus could facilitate the healing process.

Supporting women in deciding for themselves. Nurses have a crucial role in creating an environment conductive to self-exploration and self-directedness. Such a therapeutic environment "[allows women] to illuminate, to think about" all their options and all the facets of their decision. When supporting women in the decision- making process, nurses therefore should refrain from giving women advice even though they might ask for it. Supportive interventions by nurses should be directed at maximizing women's ability to make the decision by (a) providing women with adequate information about the full range of options to an unexpected pregnancy; (b) exploring women's feelings about rearing the child alone, adoption, and abortion; (c) exploring their needs, priorities, and personal goals; (d) increasing women's awareness about potential gains and limitations of each of the options; and (e) addressing women's ability to cope with the potential implications of their chosen option.

While respecting women's freedom to make a choice, supportive nurses must convey trust and foster women's confidence in their ability to choose what is best for them. When "be[ing[truly present with the women in their search for their own answers," nurses encourage them "to speak aloud" their own thoughts and feelings. By speaking aloud "their truths," grounded in their experiential knowledge, women can recognize "their own answers, their own solutions" to their unexpected pregnancy. Nurses need to "be sure that [women] come to that [decision] themselves" without undue influence of others. To ascertain that a choice to abort is based solely on the women's decision, nurses should explore the ways that the women reached the decision. Equally important is an assessment of women's confidence about the decision and their readiness to act upon it. "It would be [unhealthy]" to overlook a woman's need for more time and support to arrive at a reasonable and comfortable decision. Women might have been emotionally unprepared for the abortion even though they had come for the scheduled procedure. Some women might experience ambivalence about acting upon their decision, and others might feel uncomfortable. Therefore, nurses must ascertain whether the ambivalent feelings arise from the uncertainty surrounding the abortion or from the unsettled decision.

By using scaling questions (McConkey, 1997) to rate the answers on a scale of 1 to 10, nurses can determine the degree of women's confidence about their choice and their readiness to carry out the decision. For example, nurses might ask women the following questions: (a) Tell me, please, on a scale of 1 to 10 (when 10 means you are very certain about your decision to terminate this pregnancy and 1 means you are not at all certain), where would you put yourself on that scale? (b) On the same scale of 1 to 10 (this time 10 means you are absolutely confident that you can carry out your decision and 1 means you are not at all confident), where would you put yourself? When applicable, women should be asked how nurses can help them increase their confidence about the decision or their confidence in following through on it. Some women might seek clarification and validation of the decision as a means of affirmation in their choice. During this process, nurses should assist women in reviewing ways of arriving at the decision rather than the reasons for it. Prior to abortion, women do not feel that they need to justify their choice. After the abortion, justification emerges as one mechanism of coping with the experience. Nurses might therefore encourage women to keep a record of their reasons to abort, should they later need to justify their decision.

Despite the firm decision to abort, the "yes/no, no/yes" mixed feelings surrounding abortion might cause extreme emotional discomfort. Nurses can help women restore their emotional equilibrium by exploring the dilemma that produces such ambivalent feelings. This exploration requires a greater distance from the dilemma; it needs a step beyond the concrete meanings of rational thinking. By using symbols and metaphors, nurses might help women develop an emotional understanding of such a distressing experience. Also, a comforting nursing intervention which can help women minimize emotional discomfort during the procedure is "a hug or back rub," if appropriate.

Helping women bring closure. Although grieving over the losses related to abortion is considered a normal response (De Puy & Dovitch, 1997; Kesselman, 1990; Zoja, 1997), women might deny their need to grieve to protect themselves from social stigmatization. Over time, however, unresolved feelings and emotions are often channeled into a dormant form. Because literature such as drama, novels, and poetry can promote emotional catharsis and personal insight (Lanza, 1996), nurses might use various symbols and metaphors that might enhance women's psychological and spiritual healing: "[There is] a better chance of healing when a story [triggers] emotional responses, needed for review of old emotions" (Sinead). Using appropriate application of literature and metaphors, nurses can help women better understand the healing process: "[Metaphor] is so important in any teaching—to reframe, to observe and respect a process" (Ashley). Literature can also be useful in exploring coping strategies promoting closure to the experience: "It helps women discover a role model. Modeling facilitates learning" (Sinead) of more effective coping strategies.

To promote closure of the experience, nurses might also consider voluntary psychological assessment and emotional support as components of post-abortion follow-up care. Psychological assessment might include evaluation of social support resources, exploration of women's psychological responses and vulnerabilities, and appraisal of needs for emotional support. During the follow-up appointment, women should be given an opportunity to revisit the room where they had an abortion if they wish to do so. Reflections stimulated by this revisit might help women reconnect with parts of the Self they might have lost during the emotionally stressful procedure (De Puy & Dovitch, 1997). Such cognitive and emotional linkages might result in validation of the experience (Tentoni, 1995).

The personal significance of the abortion experience is underlined by the presence of empathic and compassionate others. The researcher observed this phenomenon during the focus-group interview, which produced a therapeutic interaction among the women studied. This interaction resulted in validation and development of a new perspective on experiences associated with abortions. The healing power of the presence of supportive others was reported by three participants who were able to validate their experiences in a ritual gathering or a burial ceremony. A post-abortion support group might offer women a similar therapeutic milieu (Hutchison, 1997; Zoja, 1997). It might also decrease the potential risk for social isolation. Nurses might have an important role in helping women organize a support group. To minimize the impact of the lack of social support and social stigmatization, nurses need to help women mobilize an adequate support network and help them gain access to supportive agencies.

Supportive partners play an important role in helping women cope with the experiences associated with having an abortion. Women might wish to involve their partners in pre-abortion supportive counselling, as several participants in the study did. If desired by the women, nurses should include partners in pre- and post-abortion supportive counselling. This participation might help partners gain an understanding of the emotional aspects of coping with the abortion experience, including the decision. As a result, partners might be able to share the burden of responsibility for making the decision and offer women adequate emotional support for bringing closure to the experience. Women might wish that their partners become equally responsible for the abortion, which can be facilitated by encouraging partners to be present during the abortion procedure. Nurses should explore and respond accordingly to women's need to have their partners present during the abortion procedure.

Nursing Research

According to this study, the phenomenon of coping with the abortion experience encompasses three processes: surviving, healing, and becoming whole. However, these processes were identified by a single researcher. Although the findings of this study are consistent with clinical practice (De Puy & Dovitch, 1997, Zoja, 1997), they require further empirical validation. By repeating this study, other researchers, representing other disciplines (Strauss & Corbin, 1990) or theoretical perspectives might generate different theories. Such studies would contribute to a better understanding of coping with experiences of having an abortion. It is also important to repeat this study on women with a wider range of ethnic and socioeconomic backgrounds. Diversity of the sample would expand applicability of findings among women with various ethnic and socioeconomic characteristics.

In addition, the coping processes proposed in this study require validation in nursing practice. For example, nurses interested in applying the findings to women seeking adequate support as they go through the abortion experience must validate suggested coping patterns through their own practice. This validation will help nurses determine whether the findings are applicable to women with whom they work. The clinical utility of coping themes identified in this study should also be determined by further empirical investigation. Future research might focus on the nurses' perceptions of supporting women through the abortion experience. A better understanding of support from the nursing perspective might direct the development of instruments to measure the quality of nursing practice in abortion clinics.

This study provides a conceptual framework on which a testable hypothesis and subsequent qualitative and quantitative studies can be based. For example, the significance of loss and grief associated with abortion can be tested through quantitative inquiry. Future research might explore in depth the meaning of the abortion experience and the related concepts of loss and grief. Such studies would be complementary to this study which offers insight into the women's coping behaviors in the context of social interactions. Phenomenological studies could illuminate the lived experience of abortion, thereby providing a broader understanding of the significance of abortion in women's lives. The development of a broad spectrum of scientific knowledge from the women's perspective would help to create a strong foundation for clinical practice. Application of scientific knowledge would increase nurses' accountability for the quality of care delivered to women contemplating and undergoing abortion, as well as those living through the experience.

For the majority of women, partners play a significant role in supporting them during the decision-making process. However, partners lacking adequate insight or supportive skills are unable to support women sufficiently (De Puy & Dovitch, 1997; Zoja, 1997). Therefore, the need for future inquiry into men's perceptions in supporting women (Cozzarelli, Sumer, & Major, 1998) during the decision-making process is critical. By gaining an increased understanding of men's perceptions in supporting women, nurses can develop guidelines for men to help them learn more effective supportive skills. There is a need for relevant investigations aimed at exploring the meaning of abortion for men and their coping strategies. Such studies might result in knowledge that might help nurses understand the partners' needs for support. Adequately supported partners would be better able to carry on their supportive roles to help women cope with their abortion experience.

On the eve of medical abortion (oral administration of an abortifacient called *mifepristone*—RU 486), nurses need to be alert to the potential implications of the extreme social isolation and secrecy that might surround this process: "The woman would no longer be alone among other women; she would be truly alone" (Zoja, 1997, p. 137). Although the procedure of medical abortion is far more simple, coping with such experience in solitude might become more complex. Future studies might consider exploring the emotional needs of women undergoing medical abortion as well as of those coping with such an experience. The outcomes of the above studies might help to develop a conceptual framework upon which nurses can develop the appropriate care plan.

Strengths and Limitations

Aside from the disadvantages in its design, the study had several strengths. Twelve women who had experiential knowledge of coping with the abortion experience voluntarily participated in this study. Although the participants had had an abortion 0.33 to 32 years ago, they vividly recalled and exhaustively described their experience. A broad opening question (Appendix G) enabled the participants to share their stories from beginning to end. The advantage of telling the story from the beginning was indicated by one of the participants: "I think that would put me in the state [of mind allowing] feelings and emotions [to] return" (Yolanda). Resurfaced feelings and emotions provoked the participants to reflect on how they coped with their experiences. For instance, while describing expressions of grief, one participant stated: "It seemed far away, although now, right at this moment, it doesn't feel all that far away" (Olivia).

Although the opening question (Appendix G, #1) did not directly address the phenomenon under study, it did encourage the participants to describe major coping patterns. Often the researcher obtained confirmation and further description of coping mechanisms by addressing a more direct question (Appendix G, #2). Although it was considered "a good question," several participants found it difficult to reflect on their coping behaviors without reflecting on a more specific aspect of the abortion experience. However, many questions, aimed at a more thorough exploration of the coping phenomenon (Appendix G), were often answered by the participants prior to the question's being posed. An appropriate set of questions and good informants who provided exhaustive descriptions of their experience as per the theoretical needs of the study ensured data appropriateness and data adequacy. The unstructured interviews allowed participants to take a lead in sharing their stories. Allowing freedom and following the lead of the participants, the researcher was able to obtain a clear picture of each participant's reality.

The researcher's adherence to ethical conduct and concern for the well-being of the participants (Sieber, 1993) minimized the risks associated with in-depth interviews and increased the possibility of unanticipated benefits (Hutchinson, Wilson, & Skodol Wilson, 1994). Her unbiased and nonjudgmental attitude resulted in unintended therapeutic effects for several participants during the individual and focus-group interviews: "[I]'ve never seen anyone with nonverbal support as you . . . give" (Paula); "Just sharing stories is so valuable [in reflecting on] what we did or didn't do" (Sinead). Mutual comfort, trust, and respect allowed the participants to share their stories honestly: "Probably you're the only person I've told about it" (Barbara). As well, the researcher was alert to her own personal beliefs about the phenomenon under scrutiny. To capture the empirical reality outside herself and thus limit the potential bias, the researcher used bracketing of her own perspective prior to each data collection and analysis. As confirmed by the supervisor of the study, friends, and colleagues, the researcher's interpretation and conceptualization captured the context of the data. Credibility of the study was also demonstrated by validation of the emerging conceptual themes by the participants of the focus-group interview and by the three secondary participants. As Morse and Field (1995) suggested, validation of the theory is sought from primary participants. Two of the nine primary participants and one secondary participant who were asked for validation of the theory recognized the coping patterns as their own (Sandelowski, 1986). The fittingness of the study is indicated in the applicability of emerging theory outside the study situation (Morse & Field, 1995; Sandelowski, 1986). Such applicability was confirmed by two women who have had an abortion but were not involved in the study. In addition, the theory that emerged fits into what is already known in this field.

Audibility, another strength of the study (Morse & Field, 1995), was achieved by consistent writing of field notes and memos (Rodgers & Cowles, 1993). Documentation of her own thinking process allowed the researcher to develop deeper insights into the emerging concepts. As such, the reader was able to follow the conceptual development of the theory.

Several limitations of the study might have influenced the findings. First, despite the researcher's effort to obtain participants with a wide range of ethnic and socioeconomic backgrounds, only White, professional women participated in the study. Second, the researcher's East European name and accent could have introduced bias into the study. Potential participants could have found it far more difficult to share personal, emotionally loaded experiences with a double stranger. For this reason, seemingly the most assertive individuals who were able to confront all the challenges surrounding abortion entered the study. Third, despite the intention of the researcher to interview the participants twice, only one participant agreed to share her story the second time. The second set of interviews was aimed at exploring the data in more depth. The participants, however, claimed to have shared an exhaustive description of their experience during the first interview. Also, no new information was obtained from the participant who was interviewed the second time. Similarly, the gathered data from the focus-group interview was repetitious.

Fourth, the size of the focus-group interview was smaller than anticipated. Only three of the five women participated. A new participant who had not been interviewed previously also decided to remain absent from the focus group. Although the participants confirmed the emerging concepts, insights from new participants might have added a new perspective or further support of conceptual themes. Fifth, one of the tape recorders stopped recording the focus-group interview. This technical problem forced the researcher to retrieve a certain portion of poorly audible data from the second recorder and from her immediate recollection of the interview. Despite the repetition and consistency with the data from previous individual interviews, the likelihood of missing or slightly distorted data has to be acknowledged.

The findings of this study, grounded in the women's experiential knowledge, offer deep insights into several difficult issues surrounding abortion that require further investigation. These findings might also provoke meaningful reflections and thoughtful discussions, thereby inspiring other researchers to investigate these issues from different perspectives and by using different methods of scientific inquiry.

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APPENDICES

APPENDIX A

ADVERTISING POSTER

THE EXPERIENCE OF ABORTION: WOMEN'S VOICE

I am a graduate student in nursing, University of Alberta, who is researching women's experience of having an abortion. If you have had an abortion at age 18 or over and you are willing to talk about your story, please contact me. I will be glad to talk to you about my study.

For more information, please call **489 - 7203**.

APPENDIX B

INFORMATION FOR POTENTIAL RESEARCH PARTICIPANTS

Call 489 - 7203 For More Information

THE EXPERIENCE OF ABORTION: WOMEN'S VOICE

My name is Jadwiga Straszynska. I am a graduate student in nursing at the University of Alberta. I am doing a research study on abortion. I would like to find out how women deal with their experiences and situations concerning abortion. Little is known about this topic directly from a woman's perspective. This study might provide nurses with new information that is necessary for better understanding and care for women.

If you have had an abortion at age 18 and over and you are willing to talk about your experience, you might wish to join this study. If you join this study, you would meet with me once or twice or talk to me on the telephone about your experience. These interviews in person or on the phone could take from 54 to 60 minutes each time. However, the final amount of time talking to me is your decision. We will meet at a time and place that are convenient and acceptable to you. Our conversations will be tape recorded, then transcribed onto paper. Your name will be erased from all written materials. All tapes and typed materials will be marked with a code name and locked in a filing cabinet to protect your privacy.

If you wish, you might join a group discussion, which is a group of women who have had abortions and meet to talk about their shared experiences. You might also share with me a diary that you might have been kept during the time of abortion, or write one for this study. It is your decision how you wish to participate. You decide, and your choice always is respected.

If you wish to get more information about this study, please contact me at *489-7203*.

If I do not answer your call, please leave a message on the answering machine. I will return your call as soon as I can. I will be glad to answer any questions that you have about this study. If you choose to take part in the study, please phone me to schedule a meeting at your convenience. Please know that you may withdraw from the study at any time, without an explanation. Your participation will be confidential.

Thank you.

Jadwiga Straszynska, RN.

APPENDIX C

DEMOGRAPHIC DATA COLLECTION SHEET

Please fill out the personal information which describes you:

1. Age ________
2. Marital Status ________
3. Number of children ________
4. Number of abortions ________ One ________ More
5. Number of years/months since abortion/s you talk about in this study ________
6. Type of present job ______________________________
7. Education - Last grade completed ________

APPENDIX D

CONSENT FORM FOR INTERVIEWS

Title of Research:
The process of coping with the experience of abortion

Researcher:
Jadwiga Straszynska, M.N. Candidate
Faculty of Nursing, University of Alberta
Telephone: 489-7203

Supervisor:
Patricia Valentine, RN, PhD
Associate Professor of Nursing, University of Alberta
Telephone: 492-6465

Purpose of the Study:

The purpose of this study is to find out how women deal with their experiences and situations concerning abortion. This study might result in a better understanding of the experiences that go along with abortion. With a better understanding, nurses might give better care.

Procedures:

If you are interested in joining this study, your participation may involve the following: Interview/s in person or over the telephone, a group discussion, writing a personal diary, or sharing one that you may already have. You are free to choose any part/s of the study. **If you choose an interview, you may wish to sign this form.** I will interview you once or twice. The time and place will be chosen by you. The interviews, personal or on the phone, will last as long as you want. I will ask you questions about your experience with abortion and how you have dealt with such an experience. You may refuse to answer any questions you do not feel comfortable answering. I will tape your story on a tape recorder. I will mark your tape with a code name know only to me, and later a secretary will transcribe your story from a tape onto paper. I will erase all names and anything that may identify you from the transcripts. Marked with a code name, the transcripts and the tapes will be kept in a locked filing cabinet throughout the study. Only the researcher can open the cabinet.

Confidentiality of Your Identity:

All information about you and your story will be kept strictly confidential. No one except the researcher will know that you are in the study. If you wish, I will erase the tape recordings when the study is over. All typed material will be kept locked for seven years after the study is completed, at which time the typed material will be destroyed. Consent forms will be locked separately from the typed material and destroyed after five years. Your real name, age, and address will not come up in any descriptions or talks about the study. I will use only anonymous quotes in the final report or other descriptions of the study. To protect your privacy, I will follow all the directions you give me to contact you during the study.

***Voluntary Participation*:**

It is strictly your choice to take part in this study. Taking part in this study or refusing will not affect the health care that you may need. You are free to quit at any time without an explanation. Your name will be kept confidential. To quit, simply phone or write me saying you want to quit. The information you have given before your withdrawal will be used only with your permission.

Risks and Benefits:

There will not be any cost to you for taking part in this study. You will not be paid for joining this study. You may not benefit from this study, except that you may find it helpful talking to me about your experience. There will likely be no harm to you if you join this study, except that you may find that there are things that are painful to talk about. You do not have to talk about anything you do not wish to talk about. You are free to stop the interview at any point. I may ask you to see your physician or a support person for a health concern that you may have while being in the study. You do not need to follow any of my suggestions. If you wish, I will give you a list of names of other support persons who you may want to see.

***Use of This Research*:**

Information that you give in the study may be used for future studies about women who have had abortions. Any future study must first be approved by an ethics committee, as this one has been. The final report of this study might be used for publication and education. If you wish, I will give you a copy of the summary of the study.

If you have any more questions or concerns about this study, please ask me now. With any future questions or concerns, you may call me, Jadwiga Straszynska, at any time at 489-7203.

Consent:

I, _________________________, have read this consent form, and I understand the purpose and procedures of the study. I freely agree to take part in this study, called "Coping with the Experience of Abortion." The researcher, Jadwiga Straszynska, has given me the chance to ask any questions I have about the study. I am satisfied with all the answers given to me. I know that if I have any future questions or concerns about the study, I can call Jadwiga Straszynska at any time at 489-7203.

I know that if I do not take part in this study my care will not be affected. Also, I am free to leave the study at any time, with no explanation. I know that during the study, if I have a health concern, the researcher may suggest that I see my physician. I do not need to follow any suggestions the researcher might give me. If I wish, the researcher will give me a list of names of other support persons who I may want to see.

I understand that I will not be identified in any way in all descriptions of the study. I know that information I give to this study may be used in future studies. If this is done, the study will have to be approved by an ethics committee.

If I wish to join the group discussion or share a personal diary about my abortion, I will sign a separate form. I have been given a copy of this form to keep.

Signature of participant _______________ Date ________

Signature of researcher _______________ Date ________

APPENDIX E

CONSENT FORM FOR A FOCUS-GROUP INTERVIEW

Title of Research:

The process of coping with the experience of abortion.

Researcher:

Jadwiga Straszynska, M.N. Candidate.
Faculty of Nursing, University of Alberta
Telephone: 489-7203

Supervisor:

Patricia Valentine, RN, PhD
Associate Professor of Nursing, University of Alberta
Telephone: 492-6465

Purpose of the Study:

The purpose of this study is to find out how women deal with their experiences and situations concerning abortion. This study may result in a better understanding of the experiences that go along with abortion. With a better understanding, nurses may give better care.

Procedures:

If you are interested in joining this study, your participation may involve the following: Interview/s in person or over the telephone, a group discussion, writing a personal diary about your abortion, or sharing one that you may already have. You are free to choose any part/s of the study. **If you choose to take part in a group discussion, you may wish to sign this form.** You can join a group of five women who have had abortions and meet to talk about their shared experiences. The group session will be carried out by the researcher. Our conversations about dealing with experiences of having an abortion will last from 60 to 90 minutes, and will be tape recorded. The group discussion is confidential, and all opinions are respected. The taped discussion will be transcribed by a secretary. I will erase your name or anything that may identify you from the transcripts. The tape/s and the transcripts will be locked in a filing cabinet throughout the study. Only the researcher can open the cabinet.

Confidentiality of Your Identity:

All information about you and your story will be kept strictly confidential. No one except the researcher will know that you are in the study. If you wish to join the group discussion, you may use a fake name to hide your identity. Still, someone in the group may recognize you and may fail to keep your name and your information confidential. I will erase the tape recordings when the study is over. All typed material will be kept locked for seven years after the study is completed, at which time the typed material will be destroyed. Consent forms will be locked separately from the typed material and destroyed after five years. Your real name, age, and address will not come up in any descriptions or talks about the study. I will use only anonymous quotes in the final report or other descriptions of the study. To protect your privacy, I will follow all the directions you give me to contact you during the study.

***Voluntary Participation*:**

It is strictly your choice to take part in this study. Taking part in this study or refusing will not affect the health care that you may need. You are free to leave the study at any time, without an explanation. To quit, you may simply phone or write me saying you want to quit. Your name will be kept confidential. The information you have given before your withdrawal will be used only with your permission.

Risks and Benefits:

There will not be any cost to you for taking part in this study. You will not be paid for joining this study. You may not benefit from this study, except that you may find it helpful sharing your experience with other women or me. There will likely be no harm to you if you join this study, except that you may find that there are things that are painful to talk about. You do not have to talk about anything you do not wish to talk about. You are free to leave the group at any point. I may ask you to see your physician or a support person for a health concern that you may have while being in the study. You do not need to follow any of my suggestions. If you wish, I will give you a list of names of other support persons who you may want to see.

***Use of This Research*:**

Information that you give in the study may be used for future studies about women who have had abortions. Any future study must first be approved by an ethics committee, as this one has been. The final report of this study might be used for publication and education. If you wish, I will give you a copy of the summary of the study.

If you have any more questions or concerns about this study, please ask me now. With any future questions or concerns, you may call me, Jadwiga Straszynska, at any time at 489-7203.

Consent: I, _________________________, have read this consent form, and I understand the purpose and procedures of the study. I agree to join this study, called "Coping with the Experience of Abortion." The researcher, Jadwiga Straszynska, has given me the chance to ask any questions I have about the study. I am satisfied with all the answers given to me. I know that if I have any future questions or concerns about the study, I can call Jadwiga Straszynska, at any time at 489-7203.

I know that if I do not take part in this study my care will not be affected. Also, I am free to leave the study at any time, with no explanation. I know that during the study, if I have a health concern, the researcher may suggest that I see my physician. I do not need to follow any suggestions the researcher might give me. If I wish, the researcher will give me a list of names of other support persons who I may want to see.

I understand that I will not be identified in any way in all descriptions of the study. I know that information I give to this study may be used in future studies. If this is done, the study will have to be approved by an ethics committee.

If I wish to have a personal interview or share a diary about my abortion, I need to sign a separate form. I have been given a copy of this form to keep.

Signature of participant _______________ Date ________

Signature of researcher _______________ Date ________

APPENDIX F

SAMPLE LETTER OF INVITATION TO A FOCUS-GROUP INTERVIEW

Name and address of participant

Thank you for accepting my invitation to join the group discussion at _______________ in _______________ on _______________. The address is _______________.

I am looking forward to meeting you at the group session that is strictly a research project. Your participation is greatly appreciated, and your sharing in the group discussion will aid in making this research a success.

The discussion group you will be attending will be a forum for women who have had an abortion. We will be talking about what it is like to go through this experience, and I would like to get your opinions on this issue.

If for some reason you find you are unable to come, please call me as soon as possible at **489-7203.**

Refreshments and beverages will be provided.

Thank you

Sincerely,

Jadwiga Straszynska

APPENDIX G

RESEARCH QUESTIONS

1. Women who had an abortion may have had different experiences. I am interested in learning how it was for you. Please tell me the story of your experience in having an abortion.

2. How did you go through your experience of having an abortion?

3. How do you feel about your abortion?

4. What did you learn from your abortion?

5. What would you tell a pregnant woman considering an abortion?

6. How can health professionals who deliver abortion care help women better cope with their experiences?

7. What was the most difficult aspect of your abortion experience? How did you come to terms with it?

8. What would you do differently to make the abortion experience easier on yourself?

9. Any coping strategies you wish you had employed to help you go through the experience?

10. Some women find it difficult to carry out their decision to abort. How was it for you?

11. Some women keep their abortion a secret. What do you think about this?

12. Some women experience and grieve over the losses associated with their abortions. What is your opinion about this?

13. For some women, coping with the abortion experience can be enduring. What do you think about using a metaphor such as "climbing a tree" to capture these efforts?